THE ADULT OUTCOME OF CHILD PSYCHOANALYSIS: A LONG-TERM FOLLOW-UP STUDY

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ABSTRACT

This dissertation presents the development and findings of a long-term follow-up study of adults who received psychoanalytic treatment in childhood and adolescence at the Anna Freud Centre in London. It reviews the existing literature on outcome research of child psychotherapeutic interventions, highlighting the advances that have taken place in the last fifteen years, alongside a host of methodological challenges that continue to confront researchers in the field. Particular emphasis is given to the relative lack of outcome studies focusing on psychodynamic interventions, despite their wide usage in clinical practice, and the dearth of follow-up studies which investigate post-treatment gains beyond termination. Given the impact of developmental changes on the long-term sequelae of childhood disturbances, the need for follow-up assessments across the life span is emphasized. In addition, the dissertation discusses the limitations of outcome measures that focus solely on the symptomatology, recommending multi-level assessment procedures that incorporate a more diverse and comprehensive approach to the assessment of functioning and treatment outcome. This approach recommends the inclusion of both disturbance and functioning, and the importance of both risk and protective factors.

The development of a comprehensive adult assessment interview protocol is described and the thirty-four treated subjects that comprise the study's sample are presented. Childhood variables assessed retrospectively on the basis of subjects' case files are described along with current adult demographic data. The Adult Functioning Index, based on five individual assessment measures, is presented and the relationship between childhood variables and adult functioning is analyzed. The findings highlight the importance of pre-treatment global functioning level in childhood as the best predictor of adult outcome, followed by the number of psychiatric diagnoses at the conclusion of treatment in childhood. The study's results highlight the relationship between security of attachment and adult functioning, suggesting that a secure attachment status may play a pivotal role in overcoming a poor long-term prognosis. The potential impact of treatment in childhood on security of attachment and subsequent development is discussed. The contributions and limitations of the study are outlined and recommendations for future prospective studies are described.

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CHAPTER 1. THE PREVALENCE AND NATURAL HISTORY OF PSYCHOSOCIAL DISORDERS IN CHILDHOOD AND ADOLESCENCE

Interest and research into the psychological disorders of childhood and adolescence have lagged behind that of adult psychopathology. Ignorance regarding the nature and extent of child disturbances has, in part, been due to mistaken beliefs regarding children's psychological experiences and development. For many years, for example, psychiatrists did not believe that children were capable of experiencing depression. Even today, a lack of awareness that children can suffer from depression or anxiety leaves many children to suffer in silence without appropriate professional attention. Moreover, there is a widespread notion that children, on the whole, grow out of their problems. As a result, children's problems often go undiagnosed and untreated.

This perception has been slowly changing over the past 25 years. Researchers and clinicians have become increasingly interested in the area of child and adolescent psychopathology. Epidemiological studies are on the rise throughout the world enhancing our knowledge of the nature, prevalence and natural history of psychological disturbances in childhood and adolescence. In addition, the emergence of the field of developmental psychopathology has contributed important information regarding the factors that influence the onset of childhood disturbances and their impact on development across the life span. This developmental perspective has helped foster links between the fields of child and adult psychiatry and psychology, highlighting the importance of early intervention in the prevention of psychopathology later in life.

The current chapter reviews the recent history of epidemiological research and presents prevalence rates of child and adolescent psychiatric disorders. This is followed by a discussion of recent epidemiological information regarding the ways in which childhood disorders develop over time, through adolescence and into adulthood. Next, the risk and protective factors associated with the onset of child psychopathology are briefly described. Special emphasis on the protective processes underlying resilience and the ability to overcome childhood adversity is presented. Psychotherapeutic intervention in

childhood is discussed in terms of an early mediating process with the potential to alter a child's negative life trajectory and return him or her to a healthy path of development. Conclusions based on the above discussion and recommendations for future research are then presented.

1.1 EPIDEMIOLOGIC STUDIES ON THE PREVALENCE OF PSYCHIATRIC DISORDERS AMONG CHILDREN AND ADOLESCENTS: A HISTORICAL REVIEW

Epidemiology has been defined as "the study of health and illness in human populations" (Kleinbaum, Kupper & Morgenstern, 1982, p.2). According to Roberts and colleagues (1998), interest in the epidemiology of child and adolescent psychiatric disturbance can be traced back to as far as the 1920's (e.g., Wickman, 1928). However, the field has really developed since the 1960's. The last twenty-five years, in particular, have demonstrated unprecedented interest in this area. Indeed, almost as many studies on the prevalence of psychopathology among children and adolescents have been conducted since the 1980's as were conducted in the decades preceding it (Roberts et al., 1998).

In order to conduct epidemiological research it is, of course, necessary to have an agreed upon method for assessing the phenomena under investigation. Epidemiological studies of childhood disorders have borrowed heavily from approaches to adult psychiatric diagnostic systems. Two main classification systems dominate the field of adult psychiatric diagnosis today: The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, and the International Classification of Diseases (ICD), published by the World Health Organization. Both classification systems are based on the medical model which diagnoses disturbance in terms of discrete categories based on specific signs and symptoms. Thus, in order to receive a diagnosis of a particular disorder, an individual needs to meet a certain number and specific type of diagnostic criteria.

The original versions of the ICD and DSM did not include child psychiatric diagnoses. These were incorporated into the ICD-9 in 1978 (World Health Organization, 1978) and into the DSM-III in 1980 (American Psychiatric Association, 1980). Current versions

(the DSM-IV, American Psychiatric Association, 1994 and the ICD-10, World Health Organization, 1992) include a classification system for both child and adult psychiatric disorders. Epidemiological studies that predated the development of a codified classification system for child and adolescent disorders were unable to use the internationally accepted diagnostic systems of the DSM and ICD. Since the review of epidemiologic studies that follows spans almost half a decade, it is important to note that not all of the studies employed the same or even similar classification systems or assessment measures. As a result, methodological discrepancies abound and the task of summarizing data from epidemiologic studies is not straightforward.

The Isle of Wight Studies

The first large-scale survey to estimate the prevalence of child psychiatric disorders in the general population is known as the Isle of Wight Studies, conducted by Rutter and colleagues in the 1960's. This seminal work has served as the model for many later community-based epidemiological studies. In their initial study, the authors (1966) reported that between six and seven percent of 10-11 year olds on the island suffered from a psychiatric disorder severe enough in nature to benefit from psychiatric services. They divided the types of disorders into two categories and reported that one third of the children suffered from a neurotic or emotional disorder (roughly comparable to anxiety or depression in DSM terms) and two-thirds suffered from so-called anti-social or mixed conduct-emotional disturbances (Yule, 1981). Thirteen children fell outside these two categories, including eight with enuresis and five with assorted problems. Later, in the 1970's, Rutter and colleagues (1976) reported a 12% rate of psychiatric disturbance on the Isle of Wight as compared to 25.4% among inner London children.

A critical aspect of the Isle of Wight studies is the fact that the same children were assessed not only at age 10-11, but again at age 14-15 using the same methodology. As a result, the authors were able to look at the prevalence and type of disorders at different developmental stages. In the second stage, the authors found an increased prevalence rate of 21% (Graham & Rutter, 1973). Among the adolescents' disorders, emotional disturbances were the most common (12.9%), followed by mixed conduct and emotional disorders (5.8%) and conduct disorder (2.1%).

The Dunedin Multidisciplinary Health and Development Study

A second large-scale community study, begun in the 1970's in New Zealand, is known as the Dunedin Study. In this study, 1,037 babies born in a particular hospital between two specific dates were seen at age three and then followed up with a psychiatric interview on six occasions between ages six and 26 (Kim-Cohen, Caspi, Moffitt, Harrington, Milne & Poulton, 2003). The follow-up up at age eleven assessed a wide range of DSM-III diagnoses and found that 17.6% of the children met criteria for one or more diagnoses. At this age, twice as many boys than girls were assessed as suffering from externalizing disorders, such as attention deficit, conduct or oppositional disorder. In contrast, anxiety disorders and phobias were far more prevalent among girls. At age fifteen, the prevalence rate of psychopathology had risen to 22% including both single and multiple diagnoses (McGee et al., 1990). At this stage, the distribution of disorders between boys and girls was somewhat different: except for social phobia, all internalizing disorders were more common among girls, and attention deficit disorder and aggressive conduct disorder were more common among boys. At age 26, the authors (Kim-Cohen et al., 2003) found that the majority of adults with a psychiatric diagnosis had been diagnosable as children. Indeed, half of the adults who met criteria for a DSM-IV diagnosis at age 26 had qualified for a disorder between the ages of 11 and 15; 75% of the subjects had been diagnosable before age 18.

The Dunedin study builds on the methodology of the Isle of Wight studies through the use of multiple assessments. The Dunedin study, however, takes the longitudinal approach one step further, following up the same cohort from early to middle childhood, onto adolescence and into young adulthood as well. This enables a closer look at the relative prevalence rates at different life stages, as well as a better understanding of the distribution of diagnoses between the genders at different developmental periods. Perhaps most importantly, the Dunedin Study, through its follow-back methodology, enables an in-depth look at the developmental history of psychiatric disorders. Evidence from the study points to homotypic continuity from childhood to adulthood for several diagnoses. Thus, adults who were diagnosed with anxiety, depression and anti-social personality disorders at age 26 tended to have suffered from the same disorders in childhood and adolescence. Indeed, most adult disorders were preceded by childhood disorders. The authors highlighted in particular the finding that every adult diagnosis had been predated by conduct disorder and/or oppositional defiant disorder in childhood.

These findings underscore the need for a developmental understanding of psychiatric symptoms and for improved links between child and adult psychiatry.

The Great Smoky Mountains Study of Youth

A third study, the Great Smoky Mountains Study of Youth (Burns, Costello, Angold, Tweed, Stangl, Farmer, & Erkanli, 1995; Costello, Angold, Burns, Stangl, Tweed, Erkanli, Worthman, 1996), represents a large-scale, longitudinal community study that examined the prevalence of psychiatric disorders among nine, 11 and 13 year-olds. The study incorporated both DSM criteria for psychiatric diagnosis in addition to measures of functional impairment in three domains (school, home and with peers). Overall, the authors reported that 20.3% of the children met diagnostic criteria on the basis of both parent and child reports. Breaking down prevalence rates in terms of diagnostic criteria and functional impairment yielded the following prevalence rates: 63.7% of the sample did not meet diagnostic criteria nor had any functional impairment; 9.1% met diagnostic criteria but were not functionally impaired, 16.1% did not meet diagnostic criteria but were functionally impaired and 11.1% both met diagnostic criteria and were functionally impaired (Burns et al., 1995). Unique to this study is the more complex assessment procedure in which subjects were classified not only in terms of psychiatric disorder but also in terms of the quality of their functioning. Adding the dimension of functional impairment to psychiatric diagnosis broadens and enriches our understanding of the epidemiological picture underlying prevalence rates. Not all children who meet criteria for a psychiatric disorder require treatment. It is, therefore, important that epidemiological research be expanded to include additional information in order to better assess the mental health needs of children and thus improve the quality of treatments offered.

Recent epidemiological reviews

Fonagy and colleagues (2002) summarized the findings of several more recent and cross-cultural epidemiologic reviews (see Bird, 1996 and Verhulst & Achenbach, 1995). Apparently, although symptomatology rates differ from country to country, the characteristics of symptomatology demonstrate great similarities across different cultural settings. These findings are based on reviews that assessed the prevalence of childhood psychopathology using the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1981, 1983). A review of thirteen epidemiologic studies that employed DSM and ICD

diagnostic criteria found varying prevalence rates depending on country and age group, but overall averages across entire samples were very similar (28% using the ICD-9 for France, Ireland and Germany; and 29% using the DSM-III or III-R in New Zealand and Puerto Rico).

Roberts and colleagues (1998) reviewed 52 separate epidemiological studies, conducted in several different countries, which were designed to estimate the overall prevalence of psychiatric disorders among children and adolescents. In keeping with the above studies, they found that both earlier and later studies confirm that disorders of childhood and adolescence are relatively common. In their review they cite a mean prevalence of 15.8% across the fifty-two studies, with prevalence rates ranging from 1% to almost 51%. Dividing the reviewed studies by the samples' age group, the authors found the following mean prevalence rates: 10.2% in the preschool group (ages 1 to 5 or 6, based on ten studies), 13.2% in the preadolescent group (ages 6 to 12 or 13, based on twenty-one studies), 16.5% in the adolescent group (12 or 13 and older, based on twelve studies), and 21.9% in the multiple age studies (fourteen studies). These findings are roughly in keeping with Target's review (Target, 1993) that asserts that epidemiological studies from several countries indicate that approximately twenty percent of children and adolescents, at any given time, suffer from a diagnosable psychiatric disorder (Velez, Johnson & Cohen, 1989). The frequency with which children and adolescents experience psychiatric disorder is even more troubling when taking into account a lifetime prevalence rate. According to Target (1993), until the age of eighteen, approximately 49% of children have experienced at least a single disorder during the course of their youth.

Is the prevalence of child pathology increasing?

The studies described above report varying prevalence rates. These cannot be summarized into an overall prevalence figure because of a host of differences among the studies. Yet, as Roberts and colleagues (1998) have pointed out, it is of the utmost importance to gain an accurate understanding of the prevalence of psychiatric disorders among children and adolescents in order to create "sound public policy for the provision of mental health and other services" (p. 715). In the past, epidemiologists concerned themselves with tracking the overall prevalence rates of childhood disturbances. More recently, researchers have questioned whether the prevalence of child psychopathology

has remained stable over the last few decades or whether it has actually been on the rise. Clearly, an increase in prevalence rates would suggest the need to augment mental health resources, both on the preventative and treatment levels.

Investigating fluctuations in prevalence rates is no simple task given changes in reporting patterns, diagnostic labels, mental health care and research designs that have taken place during the last half century. Indeed, two recent studies arrived at opposing conclusions. Rutter and Smith (1995) conducted a study regarding psychosocial disorders among adolescents in developed countries and concluded that epidemiological evidence points to increasing rates of psychosocial disorders among adolescents since World War Two. In particular, they highlighted the rise in severe disorders including crime, suicide, depression, eating disorders, and alcohol and drug abuse. Moreover, they reported that for some disorders increased prevalence was similar for males and females whereas for other disorders a rise in prevalence applied to only one of the genders. So, for example, suicide and possibly depression have affected males more than females, whereas an increase in criminal behavior has typified females more than males.

In contrast, Achenbach, Dumenci and Rescorla (2003) portrayed a somewhat different picture based on their 23-year comparison of 7-16 year-olds at three different time periods – in 1976, 1989 and 1999. In their study, children were assessed using the Child Behavior Checklist whose ratings include competence and problem scores as reported by parents. The first stage of comparison conducted in 1989 found small but significant decreases in children's competence scores and increases in problem scores (Achenbach and Howell, 1993). In a parallel study comparing changes among Dutch children, the authors reported small but significant decreases in competence scores and increases in problems on some but not all scales (Verhulst, van der Ende, & Rietbergen, 1997). Interestingly, in 1999, parents reported significantly fewer problems and more competencies than they did ten years earlier. As compared to the 1976 scores, parents in 1999 reported similar competence scores but higher problem scores. Achenbach and colleagues suggested that Rutter and Smith's (1995) findings that adolescent disorders are on the rise likely reflect the more pathological end of the spectrum. Clearly, additional large-scale studies are needed to confirm either direction. To some extent, the years selected for comparison represent arbitrary cut-offs. As a result, repeated testing of

prevalence rates is necessary in order to provide sufficient and convincing evidence of psychiatric prevalence trends among children and adolescents.

1.2 THE DEVELOPMENTAL HISTORY OF CHILDHOOD DISORDERS

As the studies reviewed in the previous section indicate, the prevalence of psychiatric disorders among children and adolescents needs to be addressed by mental health professionals. Clinicians and policy planners require a more comprehensive understanding of the ways in which childhood symptoms unfold and develop over time in order to prioritize the allocation of resources and examine which treatments are effective not only in the short-term but in the long-term as well. There are many important questions which need to be answered in order to provide effective treatment and preventative interventions. For example: Do childhood symptoms persist over time or do they abate as widely believed? If they continue into adolescence do they remain the same or undergo some kind of transformation? Moreover, do child or adolescent diagnoses tell us anything about what can be expected in adulthood? Indeed, what is the relationship between psychiatric disturbances of childhood and their adult counterparts? Finally, what factors seem to contribute to continuity or abatement?

Clearly, longitudinal research that tracks individuals from childhood to adolescence and onto adulthood is needed in order to answer these questions (Weiss, 1996). A long-term perspective on the impact of childhood disorders has the potential to inform mental health policy makers in significant ways. So, for example, persistent disorders that continue into adulthood or are linked to different adult disorders may require greater resources than childhood problems that tend to remit spontaneously and which are not linked to later disturbance. As such, interventions in childhood that target enduring disorders, or those that are known to predict adult psychopathology, can be conceptualized as a form of preventative treatment. A further benefit of longitudinal research is its ability to identify risk and protective factors that seem to exacerbate or enhance impairment as a result of early disturbance. These factors can then be targeted by mental health professionals.

In the following section, current epidemiological data on the unfolding over time of four primary childhood disorders are presented in an attempt to provide some initial answers to the questions outlined above. Particular attention is given to the natural history of two of the major internalizing disorders (depressive and anxiety disorders) and two primary externalizing disorders (Attention Deficit Hyperactivity and Conduct Disorders). The discussion attempts to clarify whether these disorders tend to persist, remit or change from childhood to adolescence and on to adulthood, drawing out the patterns that emerge from current longitudinal data.

1.2.1 The natural history of internalizing disorders

a. Depressive disorders

The continuity of depressive disorders from childhood to adolescence

Overall, existing evidence supports the notion that the incidence of depression increases with age (Anderson et al., 1987a, 1987b; Kashani et al., 1987). According to Weiss (1996), summarizing data across studies yields the following prevalence rates according to age group: 1% among preschoolers, 2% among school-age children, and 5% among adolescents. Regarding the continuity of depressive disorders from childhood to adolescence, a longitudinal study which followed up over 100 children aged eight to thirteen who met DSM-III criteria for depressive disorders (Kovacs & Gatsonis, 1989) found that although nearly all cases of depression had remitted within three to four years, the majority of children with an original diagnosis of major depression or dysthymia had further episodes of major depression over the following five years. Moreover, they had a 20% to 30% risk of developing additional secondary disorders, such as anxiety, conduct or bipolar disorder, over the next five years. In a different study conducted by Kovacs and colleagues (1984), the findings suggested that the earlier a child experiences clinical depression, the greater the risk for more prolonged difficulties, in general, as compared to those who experienced depression at a later age.

In a longitudinal, prospective study, spanning fifteen years, Gjerde and Block (1991) evaluated the relationship between personality characteristics in nursery school and their relationship to depressive symptoms in eighteen year-olds. The authors reported only

moderate associations between the preschool child's personality characteristics and depressive symptoms in late adolescence. However, an interesting difference between boys and girls emerged. The authors found that among the eighteen year-old boys, depressive symptoms were foretold by a pre-adolescent period characterized by hostility and antisocial tendencies. For girls, in contrast, depressive symptomatology in adolescence was associated with inadequate self-esteem in earlier childhood. The authors concluded that the data seems to support the view that depression in adolescence emerges through different developmental pathways for boys and girls (Block, Gjerde & Block, 1986; Gjerde, Block & Block, 1986). These findings highlight the need to conduct separate analyses for boys and girls.

The continuity of depressive disorders from adolescence to adulthood

Longitudinal studies that follow up depressed children and adolescents into adulthood or examine the childhood histories of depressed adults, have also demonstrated a degree of continuity. Apparently, depression in childhood is somewhat similar to depression in adulthood in that in both time periods depressive disorders display high rates of recovery. Approximately half the cases of depression remit within two years (Birmaher et al., 2000; Fonagy et al., 2002). Indeed, the Dunedin study (Kim-Cohen et al., 2003) referred to in section 1.1 reported that most adults diagnosed with depression at age 26 had met criteria for a diagnosis of depression in childhood or adolescence. Others, however, have found that depression in childhood is linked in general with affective disorders in adulthood, although not necessarily depression (Garber et al., 1988; Harrington et al., 1990; Kandel and Davies, 1986; King & Pittman, 1970; Klein, Lewinsohn & Seeley, 1997; Kovacs et al., 1997).

In one study that examined the adult sequelae of adolescent depression (Kandel & Davies, 1986), high scores of depressive mood during adolescence were related to a history of psychiatric hospitalization and mental health consultations over the next nine years, but only for women. Again the interaction between gender and psychiatric disorders and the necessity to analyze men and women separately is supported. A similar picture emerges from the study conducted by Harrington and colleagues (1990) which found a three times higher risk of psychiatric treatment and hospitalization among individuals who experienced depression in childhood or adolescence as compared to their matched, non-depressed, child psychiatric subjects. More recently, Weissman and

colleagues (1999) found that individuals with prepubertal MDD displayed higher rates of mental health difficulties and service use ten to fifteen years later, including problems related to substance abuse, conduct disorder, and suicide attempts. Taken together, the data from the above studies indicates that adult depression and other affective disorders are often preceded by depression in childhood or adolescence. Moreover, early depression significantly increases the risk of a range of mental health difficulties and the need for psychiatric or psychological treatment in later life.

b. Anxiety disorders

The continuity of anxiety disorders from childhood to adolescence

Cantwell and Baker (1989) followed up a small sample of children with separation anxiety. Although only one of the nine children still had separation anxiety disorder four years later, a fourth of the sample had a variety of other disorders, including two disruptive disorders and three overanxious disorders. The remaining four children were all functioning well. Indeed, the literature tentatively suggests that separation anxiety may be associated with a range of separation difficulties in adult life, including crises over leaving home or changing jobs (Werkman, 1987), continued separation anxiety disorder in adulthood and neurotic depression (Flakierska, Lindstrom & Gillberg, 1988), work phobia (Coolidge et al., 1964), and agoraphobia (Gittelman & Klein, 1984; Rutter, 1985). The Cantwell and Baker study also found that of the fourteen children referred for treatment due to avoidant disorder, 29% still had the same disorder four years later, and 64% were still considered to be psychiatrically ill, the majority with overanxious disorder.

In a community study conducted by Kashani & Orvaschel (1990) in which 210 children aged 8-17 participated, the long-term effects of anxiety disorders across all the age groups were quite sobering. In each age group, children with anxiety disorders had higher rates of all other disorders than their non-anxious peers. In addition, the anxious children failed to show the improvement in peer relations over time as was found in other children. In the area of family relationships, the anxious children showed an increasing frequency of problems in the older groups whereas the non-anxious children showed a steady level of difficulties across the age range. Additional signs of poor adjustment were also increasingly frequent among the older anxious children. For example, at eight

years of age, the anxious children showed more signs of psychopathology than others, but were reasonably well functioning in other ways. By twelve years of age, they had more difficulties at school and poorer self-image than their peers, and by seventeen they were more likely to be depressed, show behavioral disorders and somatic complaints, and had significantly poorer self-esteem than non-anxious adolescents. Taken together, these findings not only highlight the continuity of anxiety from childhood to adolescence, but also demonstrate the increasing pervasiveness of anxiety disorders as anxious children develop into adolescents.

The continuity of anxiety disorders from adolescence to adulthood

The relationship between anxiety in childhood or adolescence and adult anxiety disorders is somewhat less clear. Majcher and Pollack (1996) reported an association between a history of childhood anxiety disorder (including separation anxiety disorder, overanxious, social phobia or avoidant disorder) and increased rates of comorbid adult anxiety (Pollack et al., 1990, 1992). So, too, the Dunedin Study (Kim-Cohen et al., 2003) reported strong links between adult and child anxiety. Evidence suggests that ongoing anxiety can lead to pervasive and lasting impairment across the life span (Fonagy et al., 2002), including persistent academic and vocational underachievement, under-developed social abilities, and increased medical care use (Kane & Kendall, 1989; Keller et al., 1992; Popper, 1993). At the same time, studies have shown that some childhood anxiety disorders seem to remit spontaneously, although they are often replaced by other disorders or develop into a range of later disturbances (Fonagy et al., 2002). Because anxiety disorders in childhood often go undetected they tend to receive relatively less professional attention. Indeed, Majcher and Pollack (1996) concluded that the potential long-term effects of early anxiety disorders have yet to be fully appreciated. It would seem, therefore, that future research should focus more specifically on the long-term sequelae of childhood anxiety.

1.2.2 The natural history of externalizing disorders

As is the case for internalizing disorders, disruptive disorders seem to show a degree of continuity across the life span. In fact, common to all types of disruptive disorders is their tendency to persist over time (Pepler & Rubin, 1991; Robins & Rutter, 1990). What

is perhaps of greatest concern is the recent evidence (Kim-Cohen et al., 2003) reported in the Dunedin Study that found that all adults who met criteria for psychiatric diagnoses, both emotional and disruptive, had met criteria for at least one disruptive disorder in childhood. More specifically, the full range of adult psychiatric diagnoses was preceded by conduct and/or oppositional defiant disorder in childhood.

a. Attention Deficit Hyperactivity Disorder (ADHD)

The continuity of ADHD from childhood to adolescence

In the Cantwell and Baker study (1989) referred to before, 64 children who were diagnosed with one or more of the three disruptive disorders were followed up over a five-year period. They found that 87% of the children were still diagnosable after five years. In particular, ADHD showed an 80% persistence rate. This pessimistic picture of the natural history of ADHD was later confirmed in a larger-scale study of 4-12 year-olds conducted by Fisher and colleagues (1993). In their study, 85% of the children retained a diagnosis of ADHD after eight years. Similarly, Biederman and colleagues (1999) reported that 80% of children diagnosed with ADHD maintained the diagnosis five years later or into adolescence, with a risk for substance abuse among adolescents.

The continuity of ADHD from adolescence to adulthood

ADHD is not recognized as an adult disorder in the DSM or ICD classification systems and it is still widely believed to remit by adulthood. However, recent evidence does not support this viewpoint. Hechtman (1996) concluded, on the basis of several prospective studies, that approximately 70% of adolescents who had ADHD in childhood continue to suffer from a range of difficulties (academic, social, personality, poor self-esteem, and anti-social behavior), many of which meet criteria for continued ADHD. Fisher and colleagues (1993), for example, reported a high risk of continued behavioral problems in an eight-year follow-up study. Weiss and Hechtman (1986) found that among children diagnosed with ADHD, 60% still meet criteria for ADHD in adulthood. Based on these and other studies, Hechtman (1996) concluded that although adult outcomes vary tremendously, there are generally three typical scenarios. In the first scenario, individuals with ADHD function fairly well into adulthood. In the second scenario, characterized by a small percentage of hyperactive children, individuals go on to suffer in adulthood from severe psychiatric or antisocial pathology, including drug or alcohol

abuse. In the third and most common scenario, individuals with ADHD continue to have significant difficulties related to concentration, impulsivity, and social and emotional functioning. These individuals frequently experience a wide range of difficulties in the work place and within their interpersonal relationships.

b. Conduct Disorder (CD)

Overall, the evidence to date overwhelmingly points to a continuity of CD from early to late childhood (Campbell, 1995), through to adolescence (Lahey et al., 1995; Offord & Bennett, 1996), and into adulthood (Farrington, 1991, 1995). The studies referred to below examined the relationship between antisocial behavior in childhood and antisocial behavior in adulthood, sometimes following up the same individuals through adolescence as well. As a result, the continuities of CD from childhood to adolescence and from adolescence to adulthood will be presented together.

The continuity of conduct disorder from childhood to adolescence and on to adulthood

Several longitudinal studies point to the negative trajectory of conduct disorder in childhood. An early study conducted by Robins (1966) followed up patients who were treated at the Municipal Child Guidance Clinic of St. Louis in the 1920's. She found that children referred to the clinic with antisocial symptomatology had poorer adult outcomes than those referred for non-antisocial behaviors. In addition, the majority of adults who met criteria for antisocial personality had been antisocial as children. In a more recent prospective longitudinal study, the Cambridge Study in Delinquent Development, Farrington (1991) followed up 411 male subjects from age eight to 32 (seen again at ages 10, 12, 14, 16, 18, 21, 25 and 32). He, too, concluded that aggressive behavior in childhood predicted aggression in adolescence, and the two together predicted aggression and violence in adulthood. Factors that seem to influence the persistence of CD into adulthood include unusually early onset, high rates of problem behaviors, a variety of problematic behaviors (such as theft and violence), and the demonstration of problem behaviors across multiple settings such as school and home (Loeber & Keenan, 1994). Based on numerous studies, Offord and Bennett (1996) concluded that not only is childhood CD associated with CD in adulthood, but it also predicts a range of other psychiatric diagnoses in adulthood and widespread social dysfunction. These include alcoholism, drug dependence, and antisocial personality disorder to name but a few (see

Robins & Price, 1991). Similarly, in a study conducted at the Maudsley Hospital Children's Department that followed up children for nearly 20 years (Harrington et al., 1991; Rutter et al., 1994), CD in childhood was associated with an increased risk for adult criminality. Indeed, children with CD were 13 times more likely to be diagnosed as suffering from antisocial personality disorder in adulthood than children who did not meet criteria for CD.

Overwhelmingly, the data from longitudinal studies on the ways in which childhood disorders play themselves out over time seem to predict a rather negative life trajectory. Many childhood diagnoses seem to persist beyond adolescence and into adulthood; others remit and reappear in a different form later in life. This is true for both internalizing and externalizing disorders. While not all child depressives grow up to be depressed adults, nor do all children with ADHD remain so throughout their lives, current research points to children who suffer from psychiatric disturbances as a high risk group for later disturbances. While such youngsters indeed appear to be more vulnerable to a range of ongoing and/or later difficulties, it is also true that not all children who meet psychiatric diagnoses in childhood go on to become impaired adults (Rutter, 1995). In addition, there is evidence that psychological intervention in childhood can moderate the path from early disturbance to adult functioning (Quinton, Gulliver & Rutter, 1995). These findings bring us to the issues of individual resilience, risk factors and protective processes, and the potential for early therapeutic intervention to improve a child's functioning and reduce the chances of adult disturbance. These themes are discussed in the following section.

1.3 THE ROLE OF RISK FACTORS AND PROTECTIVE PROCESSES ON THE ONSET AND OUTCOME OF CHILD PSYCHOPATHOLOGY

1.3.1 Risk and protective factors

Over the past several decades researchers in the field of developmental psychopathology have attempted to understand the particular risk factors associated with the onset of psychopathology in childhood with a view towards early prevention. In addition to

highlighting risk and protective factors, their studies have advanced our understanding of the unique ways in which individuals respond to stress, and the factors and processes underlying individuals' coping abilities. Early studies on children growing up in high-risk environments highlighted particular characteristics associated with resilient children (Garmezy, 1984, 1985; Masten & Garmezy, 1985). These included the personality characteristics of the child (such as autonomy, self-esteem, a positive social orientation), a relationship with a warm, empathic adult (family cohesion, warmth and an absence of family discord), and a social environment that reinforces and supports the child's coping efforts. In contrast, among others, risk factors were found to include low socio-economic status, maternal mental illness, perinatal stress, poverty, family dysfunction, and low maternal education (Werner & Smith, 1977, 1982, 1992; Werner, Bierman & French, 1971).

More recently, researchers have pointed to risk factors related to temperament (Rutter, 1995), lack of a confidant (Campbell, Cope & Teasdale, 1983), poor peer relationships (Parker, Rubin, Price & DeRosier, 1995), low intelligence and socio-economic disadvantage (Seifer, Sameroff, Baldwin and Baldwin, 1992), and stressful life events (Masten & Coatsworth, 1995). In addition, they have noted that it is not the presence of any particular risk or protective factor, but rather the presence of multiple factors that predict outcome (Rutter, 1995; Sameroff & Seiffer, 1995). These findings have led researchers to look at cumulative risk factors (Masten & Coatsworth, 1995).

1.3.2 Risk and protective processes

Increasingly, developmental psychopathologists have shifted their focus from risk and protective factors to the mechanisms or processes underlying an individual's ability to negotiate risk situations (Rutter, 1995). In this vein, Cicchetti and Cohen (1995) suggested two principles – equafinality and multifinality - that offer a more complex and realistic approach to understanding the course of psychopathological disorders. The principle of equafinality refers to the observation that many paths are available to a given outcome, while multifinality refers to the fact that the effect on functioning of any one component may vary from one system to another. Taken together the two principles highlight a complex interactive process in which particular events or variables do not

necessarily lead to the same pathological or healthy outcome in every individual, and that a multitude of interactive processes can lead to the same pathological or non-pathological outcome. Such processes may help to explain not only why certain children develop psychological disturbance in early life but also why some and not others continue to suffer from the same or different disturbances throughout their lives.

Exposure to adverse experiences calls into play a complex interaction of psychological, biological and social effects which impact upon each other over time. Moreover, it appears that poor adaptation to developmental tasks at an early stage makes adaptation at the next developmental stage more difficult (Achenbach, Howell, McConaughy, & Stanger 1998). However, this developmental context is lacking in most discussions of child, adolescent and adult disorders. This is partly due to the medical model's descriptive categorical approach to psychiatric diagnosis that underlies the DSM and ICD classification systems, the most widely used instruments for psychiatric diagnosis today. These descriptive systems do not take into account the role of developmental factors in the manifestation of psychiatric symptoms nor do they account for developmental histories linking child and adult symptomatology. To date, there are very few epidemiologic studies that explore the relationship between developmental stages and psychiatric disorders (Roberts et al., 1998; Maughan & McCarthy, 1997).

Remaining within a developmental context, researchers have also pointed to the possible positive effects of later developmental stages on an individual's life course and their ability to help an individual move away from a troubled history toward a more positive life trajectory. One such mediating factor, with the potential to positively affect adult outcome, relates to turning points or new opportunities. Changes in role definition (through work, military service, higher education, religious involvements, etc.), and new relationships, for example, can redirect a risk trajectory onto a more adaptive and less vulnerable path (Masten & Coatsworth, 1995; Maughan & McCarthy, 1997; Rutter, 1995; Werner & Smith, 2001). Within this framework, it is possible to conceptualize early psychotherapeutic intervention as a protective process that serves to moderate the deleterious and long-term effects of parental and child psychiatric disorder on long-term development. Turning points and new opportunities often involve a relationship with a new and significant other (i.e., boy or girlfriend, mentor, teacher). Perhaps, one important 'ingredient' of the therapeutic process is the introduction of a significant

individual into a patient's life. Through this relationship, the therapeutic process exposes the individual to a new way of thinking and relating. As such, it has the potential to relieve a child's current distress and produce changes with a protective function as well (Follete & Beitz, 2003; Fonagy et al., 2002). In this vein, therapeutic interventions in childhood can also be seen as preventative interventions that aim not only at easing current suffering, but also at helping a child return to a more adaptive developmental path with implications for future life stages (A. Freud, 1965). By reducing disturbance and helping children to return to a normative developmental path, treatments reduce the risk of later disturbance. In the following chapter, research on the outcome of child psychotherapy, both in the short- and long-term, is reviewed and questions regarding the 'active ingredients' of psychotherapy are addressed.

1.4 CONCLUSIONS

Current epidemiological data overwhelmingly suggest that roughly 20% of children and adolescents suffer from psychiatric disorders and that they are at risk for continued and long-lasting illness and impairment. Moreover, existing research does not support the widely held belief that children outgrow their disorders. Instead, it appears that for many individuals early psychosocial disorders are associated with persistent and continued disturbance across their development. Thus, it appears that youngsters meeting criteria for psychiatric disorders are more vulnerable to later disturbance and should be considered a high risk group for later psychosocial problems. This pattern clearly underscores the importance of early therapeutic interventions that aim to both alleviate current suffering and prevent future disturbances.

Less is known about the ways in which childhood disorders remit, persist and change across the life span, although recent epidemiological studies (i.e., Kim-Cohen, 2003) have reported initial findings. Apparently, many specific childhood disorders predict a persistence of the same diagnosis into adolescence and adulthood, although that is by no means the case for all disorders. There seems to be some evidence that diagnoses that persist from childhood to adulthood tend to belong to the same general classification group, i.e. internalizing or externalizing disorders. The results of the Dunedin study

(Kim-Cohen et al., 2003), referred to in section 1.1, suggest that certain childhood disorders are more strongly linked to a broad spectrum of adult disorders and that externalizing disorders in childhood can also precede internalizing disorders in adulthood. Clearly, additional epidemiological studies are needed to enhance our knowledge of the natural history of childhood disorders. In particular, longitudinal studies that assess the same individuals on multiple occasions, in childhood, adolescence and adulthood, are needed. In this way, prospective and retrospective longitudinal studies can help clarify the ways in which childhood disorders unfold over time and elucidate the specific childhood disturbances that are most predictive of particular adolescent and adult disorders. Based on such findings, mental health professionals will be better informed as to which childhood disorders represent the most significant risk for long-term impairment and allocate funding and resources accordingly.

One of the troubling issues highlighted by epidemiologic research concerns the minimal utilization of mental health services by children and adolescents. Estimates indicate that between 15 and 20 percent of children meet criteria for psychiatric diagnoses at some point in their life. However, only a very small proportion of diagnosable youth consults for or receive psychological help (Garland & Zigler, 1994; Kolko & Kazdin, 1993; Pavuluri, Luk, & McGee, 1996). This is especially true of the internalizing disorders. Studies based in the United States have estimated that roughly 2%-3% of children and adolescents who meet psychiatric diagnoses are seen by mental health professionals (Costello, 1986; Costello & Angold, 1993; Target, 1993). This low rate of service use has been confirmed by data from community studies in New Zealand and the United Kingdom (see Costello and Angold, 1995) demonstrating that between 1% and 3% of youth who meet diagnostic criteria for a psychiatric disorder actually receive any form of professional mental health care. Understanding this 'service gap' (Stefl & Prosperi, 1985) is clearly of the utmost importance both on individual and public levels. Indeed, a better understanding of the factors affecting help-seeking behavior in the area of mental health would seem to be an important next step (Nock & Kazdin, 2001; Raviv, Raviv, Propper, & Schachter Fink, 2003; Roger & Cortez, 1993). In the case of children and youth, the issue of referral is more complex given that children generally do not self-refer, but are dependent on significant adults (parents, teachers and other important adult figures) to do so (Ho & Chang, 1996).

It is important to point out, however, that it is not yet clear whether all individuals that meet criteria for a psychiatric disorder are indeed in need of psychological help. In order to better understand which individuals require therapeutic intervention and which do not, assessment procedures need to be enhanced. To date, most epidemiological studies have based their prevalence rates on assessment instruments that classify children according to psychiatric diagnoses. Future research needs to expand our knowledge beyond symptomatology to include not only symptom presence, but symptom severity and the degree of functioning as well. Combined information regarding symptomatology and levels of impairment should provide better information regarding the extent to which mental health services are needed (Roberts et al., 1998). Data of this kind should enhance our understanding of the clinical significance of prevalence rates and, thus, improve the planning of mental health services. The issue of comprehensive and more clinically meaningful assessment is of central importance and will be further explored in Chapters 4 and 5.

A final point concerns the fact that despite the somewhat gloomy picture presented by epidemiological research, not all disordered children go on to become dysfunctional or maladjusted adolescents and adults. The field of developmental psychopathology has highlighted the important impact of resilience and risk and protective factors on an individual's development. In addition, protective processes that influence the long-term outcome of vulnerable children have been underscored. One potentially protective mediator for high risk children is the therapeutic process which offers a new opportunity and a potential turning point in a rather pessimistic life trajectory. In order to see whether psychotherapy in childhood indeed represents a protective process, studies that evaluate the long-term outcome of child therapeutic interventions are necessary. In the following chapter, a review of outcome research is presented highlighting the need for long-term studies that follow up disordered children who received psychotherapy into their adult lives.

CHAPTER 2. OUTCOME RESEARCH IN CHILD AND ADOLESCENT PSYCHOTHERAPY*

The current chapter provides an overview of outcome research in the field of child psychotherapy and presents a range of methodological difficulties that pose significant challenges to the field. In the first section, the chapter describes the most prevalent research designs, evaluating their strengths and weaknesses, and reviews suggestions for alternative research methodologies. This is followed by a discussion of the difficulty in interpreting current outcome findings in clinically meaningful ways and the complexity of selecting appropriate outcome criteria and pertinent assessment instruments. The chapter then presents an analysis of the central areas that future outcome research needs to address, focusing specifically on comorbidity, developmental issues, and the mechanisms underlying the therapeutic process that lead to significant change. Finally, the chapter offers recommendations for future research.

2.1 THE HISTORICAL CONTEXT OF CHILD PSYCHOTHERAPY OUTCOME RESEARCH

The past few decades have witnessed a virtual explosion in outcome research related to psychotherapeutic treatments for children and adolescents. According to Peebles (2000), the first published review of psychotherapy research appeared in 1950 (see Snyder, 1950). Since then, a conservative estimate has placed the number of published articles of controlled outcome studies of child and adolescent psychotherapy at 1500, a third of which have been published in the decade 1990-2000 (Hoagwood, 2000; Kazdin, 2000). This plethora of research represents an impressive achievement, given the multitude of child and adolescent therapy techniques that abound and the wide range of clinical disorders from which children suffer.

*For the remainder of the dissertation, 'child' will refer to both children and adolescents unless it is necessary to distinguish between the two groups

Kazdin (2000, 2003) reported that to date there exist 500 different types of therapeutic techniques for children, and estimated the number of possible childhood psychiatric disorders, based on the DSM-IV, to be over 200. Given that therapists often use eclectic techniques that combine aspects of different treatments, and that children often suffer from multiple disorders (comorbidity), the potential field for outcome research seems practically unlimited. This multi-faceted reality has posed formidable challenges to researchers in the field of child psychotherapy outcome. Notwithstanding, the field has experienced a good deal of progress in the last 40 years (Kovacs & Kohr, 1995), although many areas have not yet been investigated and methodological difficulties are still to be resolved. These issues will be discussed in greater detail below.

Several factors appear to underlie the growing interest in child psychotherapy outcome. Two early researchers are credited with spurring psychotherapy research. The first was Eysenck (1952) who concluded that psychotherapy had no grounds on which to claim that it achieved better effects than spontaneous remission (Miller, 2000). The second was Levitt (1957) who published similar conclusions regarding the outcome of children who did and did not receive psychotherapy. Given the general consensus that pervaded the first half of the 20th century regarding the efficacy of psychotherapy (Miller, 2000), these two publications seem to have roused researchers from their slumber, leading to increasing effort to proving the effectiveness of psychotherapy through outcome research.

A second factor contributing to the increasing focus on child treatment outcome research relates to professional organizations placing this issue at the center of their research agenda and committing resources to it. Peebles (2000) cites three major psychotherapy research conferences dedicated to this subject, sponsored by the American Psychological Association (APA) and the National Institute of Mental Health, which took place between 1958 and 1966 (VandenBos, 1996). More recently, the Division of Clinical Psychology of the APA established a Task Force in 1993 in order to establish procedures for identifying empirically supported treatments and to disseminate this information to relevant parties. Their findings, including information on the outcome of child treatment, were published in 1995. Finally, the Consumer Report survey (Seligman, 1996) recently published its findings regarding their readers' need for, use of and satisfaction with psychotherapy services (Peebles, 2000). Together, these conferences and their publications have continued to interest and engage researchers in lively, and sometimes

controversial, discussions regarding the scientific demands of outcome research leading to further research endeavors.

A third and more recent factor affecting psychotherapy outcome research is tied to changing economic realities in the field of mental health. Fonagy (1997, 1999a) and colleagues (2002) have pointed to the major changes in the delivery of mental health care in most Western industrialized countries. They cite changes in the U.S., U.K., Canada and Australia in which private services once controlled by professionals are increasingly being brought under the control of government and managed care companies. As a result, both purchasers and funders of health care are demanding cost efficient interventions of proven quality (Fonagy, 1999a; Parry & Richardson, 1996; Peebles, 2000). For the first time, providers of psychotherapy are required to provide quality treatments, along with scientific proof of their effectiveness, and to be accountable for their services. These financial forces and the demand for accountability have given yet further impetus to the burgeoning field of outcome research (Gabbard, 2000; Guthrie, 2000; Hoagwood, 2000; Jensen et al., 1996; Peebles, 2000; Petti, 2000; Weiss, 1998a, 1998b).

2.2 METHODOLOGICAL ISSUES IN OUTCOME RESEARCH

Despite the growing interest and increasing demand for outcome research, evaluating childhood therapeutic interventions remains a complex task. Researchers face a host of methodological issues regarding research design, the choice of appropriate assessment measures, and the interpretation of findings. Some of these issues are all the more complicated given that the studies focus on children who are in the throes of developmental change. These and other pertinent topics related to child treatment outcome are discussed below.

2.2.1 Research methodology

For the most part, outcome research has employed either met-analytic or randomized control trials as its methodological approach. In the following section, the findings, and

strengths and weaknesses of these two approaches are presented. In addition, alternative methodologies are described. The discussion highlights many of the problems inherent in outcome research and underscores the difficulty in determining the most accurate and clinically meaningful way to investigate psychotherapy outcome.

a. Meta-analysis

The plethora of findings from outcome studies is difficult to summarize given their heterogeneous nature. They are based on a wide range of treatments that focus on a multitude of disorders, often among varying age groups. One way to analyze such differing data sets is through the use of meta-analysis (see Mann, 1990) which enables psychotherapy outcome findings to be pooled across different studies. The central unit of analysis in the meta-analysis procedure is the effect size (ES). For most studies of this nature, the ES represents the difference between the treated and control groups' post-treatment mean on an outcome measure divided by the standard deviation of the outcome measure (Weisz & Hawley, 1998; Weisz et al., 1998). In the first stage, a single ES is computed for each individual study by averaging across the various outcome measures of each individual study. Next, an overall ES is computed by averaging the ES scores of all the studies included in the meta-analysis. In essence, this approach collapses the subjects from different studies as if they were part of the same study and reduces differences among therapists, demographic variables, types of treatment and disorders under investigation (Pearsall, 1997). To aid in the interpretation of ES scores, Cohen (Cohen, Jacob, 1977) provided guidelines according to which an ES of 0.20, 0.50 and 0.80 may be considered as small, medium and large effects, respectively.

Findings from meta-analytic studies

Overall, the findings of meta-analytic studies support the effectiveness of child interventions. Weisz and colleagues (Weisz & Hawley, 1998; Weisz et al., 1998) summarized the results of four broad-based child psychotherapy meta-analytic studies comprising a diverse range of studies, including varying disorders, age groups, and types of interventions (Casey & Berman, 1985; Kazdin et al., 1990; Weisz et al., 1987; Weisz et al., 1995b). The studies reported mean effect sizes ranging from 0.71 to 0.84, indicating medium to large treatment effects, demonstrating that treatment is more beneficial than non-treatment. These results are in stark contrast to those of Eysenck

(1952) and Levitt (1957) referred to above and are comparable to the effect sizes of studies on adult therapy outcome (Kazdin, 1991; Weisz et al, 1998).

Meta-analyses (Weisz & Hawley, 1998; Weisz et al., 1998) that targeted specific treatment modalities also found significant reasonable effect sizes for cognitive-behavioral and family therapy, as well as for a wide range of additional interventions (i.e., preparing children for medical and dental procedures, school-based psychotherapeutic interventions, and the relationship between language proficiency and psychotherapy, etc.). In addition, studies that compared behavioral and non-behavioral treatments found greater effects for the former (Weisz et al, 1998). Finally, a comparison of treatment effects immediately at the conclusion of treatment with the effects measured at follow-up assessment (approximately six months after termination) found treatment benefits to be durable (Weisz et al., 1987; Weisz et al., 1995b). These latter studies address the important question of whether treatment gains at the conclusion of therapy are maintained in the longer-term.

Criticisms of the meta-analytic approach

Despite its obvious benefits, meta-analysis has been subject to a wide range of criticisms (Fonagy et al., 2002; Kovacs & Kohr, 1995; Weisz & Hurly, 1998) related to the generalizability of its findings, clinical relevance, and methodological design. Since each meta-analytic study requires researchers to make methodological decisions regarding criteria for inclusion in the analysis, it is unlikely that any two studies will share the same guidelines. As a result, the data included in each study will differ, limiting the ability to make generalizations. For example, the majority of studies (over 75%) included in most child therapy outcome meta-analyses investigated behavioral and/or behavioral/cognitive treatments. Psychodynamically-oriented interventions are consistently under-represented (Weisz & Hawley, 1998). Thus, generalizations based on findings from meta-analyses need to be qualified as they do not necessarily relate to all forms of intervention, and do not necessarily reflect psychotherapy as it is actually practiced. Moreover, the general conclusions drawn from meta-analytic studies are lacking in treatment and patient specificity (Chambless, 2002; Fonagy et al., 2002; McCullough, 2002). As a result, meta-analytic results cannot help identify which particular treatments are most effective for specific types of patients (Beutler, 2002; Chambless, 2002; Klein, 2002; Rounsaville & Carroll, 2002; Schneider, 2002). In addition, most meta-analyses have included studies

whose subjects were not clinically-referred (Kovacs & Kohr, 1995), casting doubt on their clinical relevance. Finally, according to Weisz and Hawley (1998), meta-analyses have been applied to studies using between-group comparisons, excluding a multitude of findings from within-group and single-subject design investigations.

b. Evidence-based practice: The call for Randomized Control Trials (RCTs)

Dissatisfaction with the limitations of meta-analyses, together with the growing external demands for accountability, has led researchers to an alternative model, borrowed from the medical field. This method, known as the Randomized Control Trial (RCT) is considered the 'gold standard' of evaluation research (Fonagy, 1997, 1999a). In essence, patients are allocated randomly to various treatment and control groups (i.e., non-treatment or waiting list group), enabling a non-biased comparison of different treatment outcomes in terms of statistically significant change (Sheldrick et al., 2001). Studies of this kind allow researchers to draw evidence-based conclusions not only regarding the comparison of treatment versus non-treatment, but also regarding the relative effectiveness of different and specific types of treatment for a range of particular disorders. In keeping with the medical model, the issue of 'dosage' (Andrade et al., 2000; Hoagwood, 2000; Howard, Kopta, Krause & Orlinsky, 1986; Petti, 2000; Sheinfeld Gorin, 1993; Steenbarger, 1994) can also be examined through RCT's in which the same treatment of varying lengths (number of sessions or frequency of sessions is quantified in terms of 'dosage') can be compared, enabling conclusions regarding the efficacy of short versus long-term interventions.

The need for standardization: Manualization and core assessment batteries

In keeping with the call for evidence-based treatments, researchers and clinicians have focused their attention on two important needs: the standardization of treatment in the form of manuals (Fonagy, 1999a; Kendall & Flannery-Schroeder, 1998) and the standardization of a core battery of assessment measures (Barkham et al., 1998; Fonagy, 1999a; Strupp, Horowitz & Lambert, 1997). Manualized treatments are advantageous in that they enhance internal validity and treatment integrity (Kendall & Flannery-Schroeder, 1998). However, they require sufficient training, ongoing supervision, and quality assurance checks (via audio-taped sessions, for example) in order to ensure treatment integrity.

Regarding the use of a standardized core battery of outcome measures, at present there seems to be more talk (or publication) of the need, and less action, particularly with regard to child psychotherapy (Strupp et al., 1997). Strupp and colleagues (1997) recommend the use of two types of outcome batteries: one a so-called "universal" battery that assesses patient change in terms of symptoms, social functioning, and interpersonal functioning independent of diagnoses, and one a more "specialized" set of tests designed to assess subjects within the same diagnostic classification. Barkham and colleagues (1998) note the vast number of existing outcome measures available to practitioners today and the lack of consensus regarding a core battery. In light of this situation, they suggest several guidelines for the selection of a core battery, including user-friendliness, limited length, computer 'scannability', and an available administrative center to process data collection. Indeed, a core outcome measure in keeping with the above principles, entitled the Clinical Outcomes in Routine Evaluation (CORE) has been designed for use with an adult population (see Evans et al., 2000). To date, however, there is no such equivalent for the assessment of treatment outcome among children and adolescents.

Criticisms of the RCT approach

The call for evidence-based treatments in the form of RCTs or ESTs has not been without its share of criticism. Indeed, the topic has raised a fair degree of controversy. Fonagy (1997, 1999a) provided a succinct summary of the main criticisms surrounding RCTs. On the practical level, opponents of the RCT model cite several obstacles. First, there is the sheer number of existing therapeutic interventions to date multiplied by the large number of childhood disorders (Kazdin, 2000). Clearly, it is impossible to conduct RCTs on every possible combination of treatment and disorder. A second potential obstacle is the possible refusal of certain therapists to participate in particular types of treatments. So, for example, psychodynamic therapists may object to behavioral treatments out of a deep personal conviction. Similarly, patients may have a preference regarding the type of treatment to which they are assigned. Should patients refuse to participate in an alternate treatment or insist on a specific form of therapy they would bias the outcome results (Seligman, 1996). Finally, there is the important issue of professional ethics. Since meta-analyses have shown that having therapy is preferential to not having therapy, it would be unethical to withhold treatment from a child in distress, casting doubt on the use of non-treatment control group methodology.

Perhaps the strongest criticism of RCTs has to do with the issue of their validity. Indeed, researchers have argued that RCTs have low external validity and thus poor generalizability. In particular, clinicians have lamented their lack of relevance to clinical practice on several grounds (Fonagy, 1997, 1999a; Herbert 2003a, 2003b). First, RCTs are perceived as being unrepresentative of the health care professionals who provide treatment, the type of treatment usually offered in clinics (Herbert, 2003b; Norquist, Lebowitz & Hyman, 1999) and of the patients who receive treatment (Seligman, 1996). Inclusion criteria for RCT studies are highly restrictive, participants are often volunteers paid for their participation, they tend to suffer from single disorders and, as a whole, are a far less complex and challenged population than those seeking treatment. A final criticism relates to the fact that RCTs tend to focus on reduction of symptoms. However, many patients seek treatment with other goals in mind, such as improving relationships, functioning in the work place, coping skills, and quality of life, much of which is not diagnosable in DSM-IV terminology (Hill et al., 1989; Seligman, 1996; Westen & Shedler, 1999a, 1999b). Indeed, manualized treatments may be so atypical of clinical treatment that results from RCTs may be irrelevant to clinical practice (Garfield, 1996). In an attempt to bridge the gap between 'real life' clinical settings and laboratory research, researchers have recommended that laboratory techniques be exported to the clinic, to see which modifications, if any, are needed in order to make them clinically relevant (Dodge, 2001; Kendall, 1994; Weisz & Hawley, 1998; Weisz et al, 1998).

2.3 METHODOLOGICAL ALTERNATIVES TO META-ANALYSES AND RCTS: THE NEED FOR NATURALISTIC, CLINIC-BASED RESEARCH

Both meta-analytic and RCT studies have made important contributions to the field of outcome research. The meta-analysis approach has enabled a summary and analysis of vast amounts of differing data. However, findings have been fairly general and do not inform clinicians as to which types of treatments are best suited to particular patients suffering from specific types of disorders. RCT studies, in contrast, enable the comparison of treatment versus no treatment, as well as the comparison of alternative treatment approaches. As mentioned, a major criticism of RCT and meta-analytic studies is that both approaches have conducted most of their research in laboratory rather

than naturalistic clinical settings. As a result, much of the criticism of both approaches has focused on the disparity between clinic- and laboratory-based research.

2.3.1 The gap between clinical treatment and controlled laboratory studies

Weisz and colleagues (1998) aptly referred to two types of outcome research as based on either clinical or research therapy. They summarized the main differences between these two settings in terms of six central points (Weisz et al., 1992), presented as research versus clinic: 1) patients are recruited by researcher versus others or self-referred; 2) treatment groups are homogenous versus heterogeneous; 3) treatment is given for one specific problem versus a range of problems; 4) therapists are trained in the specific procedure under study versus variable training; 5) therapists follow a protocol versus lack of protocol; and 6) the use of a treatment manual with monitoring of adherence to it versus lack of treatment manual and monitoring procedures.

Children referred to clinics generally do not self-refer, meaning that in most cases children are initially brought to treatment by an adult. In great contrast, children who participate in controlled studies are usually drawn from school settings, volunteering to participate of their own free will. Weisz and Hawley (1998) pointed out that the issue of motivation is important. Unlike recruited youngsters who are not coerced and are motivated to receive treatment, the evidence from community clinics suggests that referred children demonstrate low motivation for treatment. Moreover, a significant percentage of their parents lack motivation as well and seek treatment only when forced to by police, social services or the court. Since recruited children tend to have only mild or sub-clinical problems, if at all, their treatment tends to be relatively brief (Kazdin et al, 1990; Seligman, 1996). In contrast, referred children tend to participate in longer-term interventions. In light of these important differences, it is not surprising that many clinicians feel that current outcome research is irrelevant to the patients with whom they work.

Clearly, the impressive findings of laboratory studies need to be replicated within clinic samples. In this vein, Weisz and colleagues (1995a) attempted to review the effects of child treatment in clinical practice. Their search turned up only nine studies, including

one of their own, which met criteria for naturalistic settings and patients. The studies spanned a fifty-year period but most had been conducted many years earlier. The effect sizes for the nine studies ranged from –0.40 to +0.29 with a mean ES of 0.01. These results fell way below the mean ES of 0.77 demonstrated by the four broad based meta-analyses for research therapy described above. Moreover, their examination of evidence from "system of care" programs for children, such as the Fort Bragg Project (see Bickman, 1996), failed to demonstrate better treatment outcomes than a comparison group. Based on these findings, the authors concluded that, at present, there is insufficient evidence to support the effectiveness of conventional clinical treatments. However, given the limited number of studies of this kind, future research findings may modify or, indeed, reverse these conclusions. Even in cases in which efficacious laboratory studies have been replicated in the clinic, community effectiveness studies tend to be conducted on a very small scale. As a result, Dodge (2001) urged that future research needs not only to replicate laboratory findings within the community, among true clinical samples, but also to examine their effectiveness within community-wide efforts on a much larger scale.

2.3.2 Treatment efficacy versus treatment effectiveness

In light of the significant distinction between controlled laboratory and clinic-based treatments, researchers have suggested different terminology regarding the study of outcome research. In particular, they recommend that *efficacy* be used to refer to treatment outcomes in controlled laboratory settings and that *effectiveness* be used in reference to treatment outcomes in clinical settings (Chorpita et al., 1998; 2002; Fonagy et al., 2002; Hoagwood & Hibb, 1995; Peebles, 2000; Weiss, 1998a, 1998b). According to Weiss (1998a, 1998b), efficacy studies place internal validity at their forefront and are often characterized by four requirements: 1) specific inclusion/exclusion criteria restricting the sample to children with only the specific problem being targeted by the treatment; 2) the sample is randomly assigned to treatment and control groups; 3) the sample is not clinic-referred; and 4) the intervention is highly controlled through the use of training, manuals, supervision, and monitoring, etc. In contrast, effectiveness studies place greater emphasis on external validity and generalizability. They tend to: 1) take place in naturalistic settings where children usually receive mental health care; 2) use

heterogeneous samples that actually seek treatment; 3) involve clinical practitioners rather than research therapists; 4) allow therapists more control over treatment procedures.

2.3.3 Methodological alternatives to meta-analysis and RCTs

As a result of the criticisms leveled at both meta-analysis and RCTs, and the limited applicability of research therapy to clinic therapy, several researchers and clinical institutions have developed alternative approaches to psychotherapy outcome research. These alternative approaches emphasize the need to investigate patients in a naturalistic setting. In addition, they emphasize the importance of understanding the therapeutic mechanisms that underlie change, both on individual and group levels.

Researchers at the Menninger Clinic (see Fonagy, 1999b for more detail on the system) developed an approach to outcome studies that they see as complimentary to the RCT model. The Menninger Outcomes Program involves the prospective collection of data, the development of appropriate outcome measurement instruments, and the ongoing monitoring of clinical outcome in relation to the services provided by the clinic. Moreover, it permits comparisons between individual patients and relevant group norms, between different patient groups, between multiple clinicians, and between various treatment settings. The system is computer assisted, staff receives training in the system to ensure reliability, and quality spot checks take place to minimize reporting biases. A clear strength of the Menninger program is its naturalistic setting, a weakness of many of the efficacy studies described above.

Nock (2003) advocates the use of progress reviews, an approach with multiple foci. This approach, like meta-analyses and RCTs, first evaluates the efficacy of a treatment. Once evidence of the treatment's effectiveness is established, the progress review goes on to address the components that are needed in order to exact change, the mechanisms through which treatment works, and the conditions necessary for change to take place. The end product of a progress review is a comprehensive report that outlines the research questions answered by previous studies and, additionally, the questions that remain unanswered. In sum, the progress review helps to establish whether or not a particular

treatment is effective, elucidates the mechanisms that underlie therapeutic change, and poses questions for future research. As such, the progress review puts forward a research agenda regarding the issues that future studies need to tackle. This approach is in keeping with Kazdin's (2000) call to establish a plan of action in the field of child psychotherapy outcome research.

Finally, several researchers have called for the renewal of assessment at the individual level of analysis (Follette & Callaghan, 2001; Ogrodniczuk, Piper, Joyce and McCallum, 2001). Canadian researchers (Ogrodniczuk et al., 2001) have suggested that traditional approaches to the analysis of longitudinal data are insufficient for understanding the ways in which individuals change over time. Ogrodniczuk and colleagues (2001) recommend the use of hierarchical linear modeling (HLM) as opposed to repeated measures ANOVAs or chi-square tests which are unable to detect significant individual changes. In their study, the authors sought to investigate change during a one-year follow-up period for patients who received either interpretive or supportive psychotherapy. In addition, they sought to predict individual change based on two personality characteristics – quality of object relations (QOR) and psychological mindedness (PM). For purposes of this discussion, what is of special interest is that the use of HLM enabled detection of significant findings that were not detected by traditional methods of data analysis. Moreover, it allowed for a more precise mapping of individual patterns of change rather than merely averaging an individual's status on multiple occasions. This approach seems highly important for researchers investigating the ways in which individuals with particular childhood disorders develop across their life span.

2.4 INTERPRETING FINDINGS FROM OUTCOME RESEARCH: STATISTICAL VERSUS CLINICAL SIGNIFICANCE

A limitation common to all of the methodologies described above, pertains to the meaningfulness of statistical significance (Kendall & Flannery- Schroeder, 1998). Traditionally, statistical analyses are subject to a significance test. When research findings meet criteria for statistical significance, researchers are free to conclude that

their result is not due to chance but rather to the research variable under study. In the case of outcome research, for example, if patient outcome is significantly better in the treatment group as compared to the non-treatment control group, we conclude that the treatment was responsible for the improved outcome. Knowing that the difference in outcome between the two groups was statistically significant, however, does not tell us anything qualitative about the nature of the treated group's outcome, other than the direction of change. Accordingly, although individuals in the treated group appear to be better off than those in the control group, we do not know whether the degree of change they have experienced is actually meaningful to them in their daily lives. Stated somewhat differently, statistical significant effects do not necessarily imply that the individual has returned to normal levels of functioning. In order to distinguish change that is meaningful from change that is statistically significant, researchers have begun to discuss the issue of "clinical significance" (Follette & Beitz, 2003; Harman et al., 2001; Kendall & Flannery-Schroeder, 1998; Nock, 2003; Sheldrick et al., 2001).

Researchers have devised a wide range of methodologies for interpreting the clinical meaning of statistically significant findings. Fonagy and colleagues (2002) summarized a number of these psychometric approaches. The first approach uses standardized measures that have known distributions for both the normal and clinical population. Pre- and post-treatment scores can be compared, demonstrating that an individual or group has moved from a dysfunctional to a functional range as the result of therapeutic intervention. These are known as normative comparisons (see Harman et al., 2001). More recently, the technique of equivalency testing had been applied to normative comparisons, enabling statistical interpretation and conclusions regarding whether a group's functioning can be regarded as having returned to normative levels (see Sheldrick et al., 2001). A second method, known as the Reliable Change Index (RCI, see Jacobson et al, 1999) sets a criterion for change in standard deviation units that exceed chance fluctuations. A third approach, appraises changes in terms of diagnostic criteria so that a child who met diagnostic criteria before treatment and ceases to meet criteria for that disorder at the end of treatment would be considered to have undergone clinically significant change.

Harman and colleagues (2001) offer an interesting elaboration to this approach, although it is derived from the realm of adult mental health. They recommend using a social

validity approach in which mental health scores are related to external criteria – in this case four major life events (psychiatric hospitalizations, victimizations, arrests, and suicide attempts). According to the authors, the social validity approach is based on the conviction that therapeutic treatments should be evaluated in terms of desirable social changes. Given the proven relationship between schizophrenia and life events, they recommend evaluating the social impact of interventions in terms of the relationship between mental health status scores on a range of measures and effect sizes to subsequent life events. By means of this analysis, they suggest, researchers can conclude that a particular intervention reduced psychiatric hospitalizations or suicide attempts by a certain percentage or increased global functioning scores by a particular amount. Presenting outcome findings in this manner makes outcome research more meaningful to policy makers, clinicians and researchers. It would seem possible to come up with parallel desirable social changes for children to enable a similar interpretation of findings in the field of child mental health research. Unfortunately, none of the approaches described above have been validated (Fonagy et al., 2002). In other words, so-called 'clinically significant' change has not yet been shown to correspond to actual and meaningful differences in the lives of treated children and their families.

It is important to point out that the meaningfulness of diagnostic labels is somewhat controversial and there is clear evidence that many individuals seek treatment despite not meeting criteria for a DSM diagnosis. Likewise there are individuals who meet criteria for disorders but who do not experience distress (Westen & Shedler, 1999a, 1999b). A fourth strategy judges clinically significant change on the evaluation of an individual who is in contact with the patient, such as the therapist or perhaps a parent or teacher. Clearly, such evaluations are subjective and therefore likely to be biased. Finally, clinical significance can be defined in terms of external criteria, such as the social impact of the behavior being investigated.

2.5 THE APPROPRIATE FOCUS OF OUTCOME RESEARCH: ASSESSMENT ISSUES

In order for outcome research to provide clinically significant findings, instruments that assess outcome need to address the features, behaviors, characteristics and domains that are the most meaningful in clinical terms. This poses a formidable challenge to researchers since positive or negative outcome can be measured along a host of dimensions and criteria. How are we to know which dimension tells us the most meaningful information regarding treatment effects? This question is, perhaps, even more complicated in the case of children and adolescents whose lives, by definition, are in the midst of developmental change and are still so dependent on significant others in their environment. Weisz and Hawley (1998) stress that in the case of children, outcome assessments should include information about the child's level of daily functioning in multiple settings, including at home, at school and with peers. For this reason, many researchers have stressed the need for multiple information sources, including parents, teachers and children themselves (Kendall & Flannery-Schroeder, 1998; Weiss, 1998a, 1998b), in order to obtain the most comprehensive picture of overall functioning across domains and situations.

Symptomatology

It is probably safe to say that the most obvious level of outcome investigation, and perhaps the most prevalent (Kazdin, 2000), relates to the assessment of symptoms and diagnoses. Yet it is probably equally true that most, if not all, clinicians and researchers recognize that symptomatology represents only part of the picture (Ritvo et al., 1999; Sheldrick et al., 2001). Kazdin (2000) warned that despite the centrality and relevance of symptoms to outcome research, "there is no compelling evidence that symptom change (as opposed to reduced impairment or improvements in prosocial functioning, family interaction, or adaptive cognitions) is the best predictor of long-term adjustment and functioning" (p. 833). For this reason, several researchers have proposed multiple domains or levels of analysis that are crucial to the assessment of treatment outcome in children. Indeed, according to Fonagy (1997) the need for multi-domain outcome assessment for children reflects the greater complexity of measurement of child mental

health outcome and underscores its relative underdevelopment as compared to the assessment of adult functioning.

Multi-level assessment

Along these lines, Hoagwood and colleagues (1996) suggested that outcome assessment includes five essential areas, the first being symptomatology. The second outcome domain refers to adaptive functioning, including functioning in school and with peers; the third level is the consumer perspective, referring primarily to child and parent satisfaction with treatment; the fourth level relates to changes in the child's environment, including social support networks and peer relationships, parental discipline techniques, and classroom disruptions; and the final domain, referred to as 'systems', includes topics such as arrest records, later use of mental health services, and cost-effectiveness of treatment. Fonagy (1997) recommended a similar list of domains to be included in all outcome research pertaining to child psychotherapy. He adds a further level of investigation which he calls the level of mechanisms, by which he refers to cognitive and emotional capacities that likely underpin symptomatology and adaptation. According to Fonagy, important mechanisms include affect regulation, understanding emotions, self-representation, understanding mental states of self and others, forming emotional bonds, making moral judgments, and attributional biases. In addition, Fonagy outlines a transactional level that refers to the ways in which children interact with their environment and the quality of these transactions. Given that treatment response and retention in children are often affected by parental and family dysfunction (Kazdin, 1991), assessing these contexts is essential for outcome research. Finally, Fonagy delineates a level of service utilization that examines the role of interventions, including preventative programs in potentially reducing the need for later treatment, and service use. He suggests that the five outcome dimensions described above could generate profile scores at baseline and that these scores could be used to predict which treatments are most suitable for specific treatment groups.

Pearsall (1997) presented yet another multi-modal set of criteria for assessing the effects of child psychotherapy, a model first put forward by Jacobson and Truax (1991). According to the model, all criteria should be based on 'face-valid benchmarks' published by earlier researchers. Minimum criteria should include: "a high percentage of clients improving; a level of change that is recognizable by peers and significant others;

an elimination of the presenting problem; normative levels of functioning by the end of therapy; high end-state functioning by the end of therapy; and changes that significantly reduce one's risk for various health problems" (p. 597). This is no small order, and it is doubtful whether any outcome studies have applied such comprehensive criteria to their data.

Patients' perspectives

A further focus of outcome research, which has received relatively scant attention, relates to what patients perceive as helpful in their treatments. In the area of adult mental health, the importance of patients' perspectives has received increasing attention in recent years (Frager et al., 1999; Macran et al., 1999). For example, Frager and colleagues (1999) posited that global satisfaction measures are insufficient and that patients need to be asked more specific questions about particular dimensions of treatment. Macran and colleagues (1999) stressed that clients' views are as important as those of clinicians and researchers. Whereas most outcome research is based on the medical model wherein the patient is perceived as passive, the authors purport that outcome measurements are meaningless if they do not take into account the meaning of change in their patients' lives. Roth, Fonagy and Parry (1996) described an evidence based research model that combines empirical investigation and clinical consensus, leading to the development of treatment protocols. This approach is, perhaps, more amenable to adult psychotherapeutic interventions.

Involving patients' perspectives is somewhat more complicated when it comes to children, raising questions regarding the extent to which children are capable of noticing, interpreting, and expressing the meaning of change in their lives. However, there have been recent attempts to explore child patients' perspectives as well as that of their parents. At the Tavistock Clinic in London, for example, researchers have begun to consider how to incorporate treated children's perspectives alongside their therapists' assessments (Lush, Boston, Morgan & Kolvin, 1998). In addition, Chorpita and colleagues (2002) presented a unique partnership between university professionals, Department of Health staff, and parents who worked together on the implementation of empirically based child psychosocial services in the state of Hawaii. These studies represent first attempts to take into account the perspectives of children and/or their parents. However, the implications of these perspectives have not yet been studied.

2.6 FUTURE DIRECTIONS FOR CHILD PSYCHOTHERAPY OUTCOME RESEARCH

The above discussion has focused on the methodological challenges facing the field of child outcome research, issues related to research design, the interpretation of findings, and the appropriate selection of outcome assessment measures. The picture that emerges is complex and multi-faceted, highlighting the multiple difficulties inherent to the field. Until now, outcome research has focused on comparing various forms of treatment and on demonstrating that child psychotherapy does, indeed, work. However, there is still insufficient data to determine which forms of treatment are best suited for specific individuals. This information is essential so as to enable clinicians to offer the most effective treatments to their clients. In order to answer this question, future outcome research needs to explore several additional and complicated issues. This section presents several pertinent areas of research that should be placed on the agenda of future outcome research. These include the need to find ways of coping with the phenomenon of comorbid disorders, the need to take into account the impact of the developmental context on child psychotherapy and its outcome, and the importance of improving our understanding of the therapeutic process. Understanding the mediating variables and the so-called curative treatment 'ingredients' is a necessary first step. So, too, pinpointing the moderating factors (such as child, environment and treatment variables) that interact with treatment mechanisms to affect change is imperative. These issues are each explored in turn.

2.6.1 Comorbidity: A challenge to outcome research

One of the thorniest issues facing researchers in the field of child psychotherapy is the high prevalence of multiple disorders among children receiving mental health care. Estimates vary regarding exact percentages, but at least 50% (Eyberg, Schuhmann, & Rey, 1998b), if not more of children meeting criteria for a single DSM diagnosis also meet criteria for at least one additional diagnosis (70-75%, see Kazdin, 1996). As mentioned, most outcome studies to date have excluded children with comorbid disorders, making it difficult if not impossible to generalize findings to clinic-referred children. Comorbidity poses numerous challenges to researchers, among them the ability

to match subjects along particular and multiple diagnostic criteria. And yet, it is crucial that this phenomenon be better understood (Chorpita et al., 1998) as the nature of childhood psychopathology is crucial to the development of effective interventions and meaningful research. Kendall and Flannery-Schroeder (1998) suggest that the presence of comorbid disorders necessitates the use of broad and comprehensive assessments both at referral and at termination. In particular, it is important to see whether effective treatment leads to favorable changes in one or more of the presenting disorders or, conversely, to the development of new and different disturbances.

Eyberg and colleagues (1998b) proposed a rather unique way to perceive comorbidity in relation to children and their families. They suggest that comorbidity be considered a dyadic phenomenon in which child and parent problems are linked (see Foote, 1998). Although the significance of parental psychopathology for child development is not a new idea, conceptualizing combinations of parent and child disorders and their implications for treatment outcome well deserves further investigation. Regardless of how one defines comorbidity, the literature gives ample evidence that children with multiple disorders represent a high-risk group. Consequently, discovering ways to improve their treatment outcome is an important challenge to child psychotherapists and researchers.

2.6.2 The centrality and complexity of developmental issues

Although clinicians working with children take it as self-evident that their patients are in the process of rapid developmental changes, the implications of this for treatment and research are multiple and complex. Kovacs and Kohr (1995) pointed out links between developmental issues and treatment strategies. They highlighted themes related specifically to cognitive development and relationship abilities that impact on treatment intervention. Regarding cognitive development, for example, the capacity for self-understanding, social perspective taking and identification of emotions have clear implications for the kind of treatment appropriate at different developmental stages. Among children referred for treatment, disorders may impair or delay certain cognitive developments. As for relationship abilities, it is generally assumed that effective therapy requires the establishment of a trusting relationship with a therapist. From a

developmental perspective, however, children's ability to engage in a therapeutic alliance with their therapist may be constrained by developmental limitations, such as the ability to acknowledge that a problem exists, and to view the therapist as a trustworthy agent and helpful individual.

Shapiro (1995) raises several thought provoking points regarding development and its implications for treatment and outcome research. For example, despite the presence of symptomatology, there may be certain times when it is best to refrain from therapeutic intervention due to developmental factors. How, then, do we know at what stages and for which problems do we or don't we intervene? A second question relates to whether it is possible to discern that a change occurred as a result of treatment or as a byproduct of the developmental process itself. He suggests that psychotherapy with children should be perceived as a means of enhancing development, in keeping with Anna Freud's concept of developmental lines (A. Freud, 1963). From a developmental perspective, therapeutic interventions intervene in the natural life cycle, sometimes at highly formative stages of development. It is, therefore, possible that treatment effects may express themselves at later stages and not at treatment termination when most treatment outcomes are assessed. This possibility underscores the need for the inclusion of follow-up assessments in all outcome studies. Given the interplay between developmentally induced change and improvement due to therapeutic intervention, the need for long-term follow-up of children into adolescence is clearly essential.

2.6.3 Understanding how the therapeutic process works

a. Therapeutic mediators

In the past few decades, outcome research has focused primarily on proving that child psychotherapy indeed works. Recently, numerous researchers have called for outcome studies that go beyond this initial question and focus their attention on the mechanisms underlying the therapeutic process that lead to clinically meaningful change. Presumably, therapeutic approaches are based on theoretical principles regarding the mechanisms that help an individual move from a dysfunctional to a functional state. Although there is no lack of theories, proof of the validity of such theories is glaringly absent. Indeed, Nock

(2003) has suggested that one of the best kept, and perhaps most embarrassing, secrets in the field of psychotherapy is that we do not actually know why and how treatment works. Partly, this situation is due to the complexity of studying causal mechanisms. Weisz and Hawley (1998) reported an attempt by Durlak and colleagues (1991) to study the effects of cognitive-behavioral therapy (CBT). The theory underlying CBT posits that changes in cognitions lead to changes in behavior. Interestingly, in their meta-analysis, Durlak and colleagues found that although treatment led to positive outcome, change in cognition did not correlate significantly with change in the target behavior. Thus, even when treatment works, we may not necessarily understand why it does. Davidson and Lazarus (1995) aptly described this state of affairs stating that techniques can sometimes be effective for reasons that are completely unrelated to the theory from which they are derived.

Miller (2000) suggested a list of promising process variables worthy of study based on psychodynamic theory (i.e., themes related to transference and counter-transference, the therapeutic alliance, and patients' mental representations of their therapists), and recommended that outcome research focus on the ways in which these variables relate to outcome. Yet, as Nock (2003) pointed out, there may be process variables that are common to all forms of therapeutic intervention that are responsible for change. Despite conspicuous differences in various therapeutic approaches, it may be that all therapies regardless of theoretical orientation, share powerful curative components (Beutler, 2002). To date, very little is known about the mediators of change in child psychotherapy. Advancing this area of outcome research has the potential to enhance treatment efficiency. By identifying the treatment mediators responsible for change it will become possible to eliminate unnecessary aspects of treatment, reinforce effective elements, and thereby lead to greater therapeutic impact (Weisz & Hawley, 1998).

b. Elucidating treatment moderators

Along lines similar to the above discussion, outcome researchers have been calling for increased focus on and attention to a range of factors that likely interact with treatment mechanisms, leading to differential therapy outcomes. For the most part, authors have tended to focus primarily on child, parent and treatment variables. Miller (2000) referred to several client variables that are known to affect treatment outcome, including

relational capacity and severity of psychiatric illness among others. It is of interest to note that although most studies collect data regarding children's age, gender, socio-economic background and ethnic identity, few studies have tested their relation to outcome (Weisz & Hawley, 1998). The role of ethnicity has particularly been ignored and several authors have called for its inclusion (Kendall & Flannery-Schroeder, 1998; Weisz et al., 1998). Diagnostic variables pertaining to children, including severity, chronicity and type of disorder have also been highlighted as potentially important moderating variables (Nock, 2003).

Contextual variables have been underscored as particularly relevant to child outcome research given that children do not live alone but rather are highly dependent on their family environment. In particular, parents' involvement with and attitudes toward their child's treatment may play an important role in treatment outcome. Among other variables, information regarding parents' mental health status is clearly important. While the inclusion of parent variables may seem self-evident, Kovacs and Kohr (1995) highlighted the inconsistent and ambiguous place that parents have received in outcome research.

Regarding treatment variables, in addition to the type, frequency and duration of treatment, researchers have focused on therapist characteristics as well as the client-therapist relationship or alliance. Therapist variables worthy of study pertain to their behavior and style, for example directness of communication, relational capacity, empathy, warmth and support. Client-therapist relationship variables have focused on positive emotional connectedness and a shared perception of the tasks and goals of treatment, to name a few (Miller, 2000; Nock, 2003; Weisz et al., 1998). At present, however, there is still a need for well-validated measures for assessing client-therapist relationships (Weisz et al., 1998).

Clarifying which of these moderating variables, alone or in combination, affect process variables leading to change will help identify which individuals are most likely to benefit from particular intervention types. Clearly, this should be an important goal of outcome research. Indeed, Nock (2003) takes this one step further. He suggests that once research has succeeded in elucidating the central mediating and moderating variables

underlying treatment outcome, researchers will also need to examine whether treatment effects generalize across different conditions, settings and populations.

2.7 CONCLUSIONS

The field of child outcome research has grown tremendously in recent years, both in quantity and quality. The last decade, in particular, has witnessed unprecedented growth and development. For the most part, current research has employed meta-analytic techniques and, more recently, randomized controlled trials for the study of treatment outcome. Both techniques, however, have received a fair degree of criticism. As a result, researchers have begun developing alternative methods for engaging in outcome research. One of the major problems in the existing literature is that most outcome research has tended to be laboratory-based, incorporating samples and therapy techniques that are unrepresentative of clinical practice. Although laboratory-based studies overwhelmingly support the efficacy of child psychotherapy, these findings are yet to be replicated within more representative clinical samples on a large scale basis. Moreover, greater attention needs to be given to children suffering from co-existing disorders. Similarly, the outcome of psychodynamic treatments requires extensive research. Despite the high prevalence of psychodynamic treatment in most clinics, this form of therapy is grossly under-represented in outcome research. To this end, an appropriate methodology for studying the outcome of psychodynamic treatment in childhood needs to be developed.

A second challenge to outcome research relates to interpreting the clinical significance of mental health findings. Most studies to date have focused primarily on symptoms and diagnoses. However, it is not at all clear that they represent the most appropriate focus for outcome research. Increasingly, researchers have called for a multi-level assessment approach that takes into account symptomatology as well as adaptive functioning across a range of domains and settings. A more comprehensive assessment approach should help match suitable treatment to specific children and thereby improve the quality and effects of treatments offered to children and their families.

There remain additional areas of outcome research that require the attention of future research. Recent literature has increasingly underscored the importance of the treatment

process and the need for researchers to elucidate the mechanisms underlying it. So, too, they have called for a better understanding of the variables that moderate the treatment process. Increasing attention to the developmental backdrop of child and adolescent disorders has highlighted the need for outcome studies to include follow-up investigations, providing a longer-term perspective on the effectiveness of therapeutic interventions over time. To date, most outcome research has failed to include meaningful assessments beyond treatment termination, and those that have done so have limited follow-up to the short-term. In the following chapter, particular attention is given to two areas of outcome research that have not received sufficient attention: the lack of outcome studies on child psycho-dynamically oriented treatments and the scarcity of follow-up evaluations that examine the longer-term duration of treatment gains.

CHAPTER 3. OUTCOME RESEARCH ON PSYCHODYNAMIC* TREATMENT FOR CHILDREN AND ADOLESCENTS: THE NEED FOR LONG-TERM FOLLOW-UP

The current chapter focuses on two areas of child therapy outcome research that, to date, have received scant attention. The first area pertains to the relative lack of research on child treatments with a psychodynamic or psychoanalytic orientation. Although this form of treatment is often the most commonly practiced in clinical settings, it has not been a central focus of outcome research. Special attention is given to a range of methodological difficulties inherent in outcome studies of child psychodynamic treatment, and a review of relevant outcome studies is presented. The second area relates to the scarcity of long-term follow-up studies for all forms of child psychotherapy, but which is particularly lacking in the area of psychodynamic treatment for children. In light of the evidence from epidemiological studies on the natural history of childhood psychopathology, as presented in Chapter 1, the need for long-term follow-up is stressed.

3.1 THE UNDER-REPERSENTATION OF OUTCOME RESEARCH IN CHILD PSYCHODYNAMIC TREATMENTS

Despite the tremendous growth in outcome research on child psychotherapy in the last few decades, for the most part outcome research has failed to include investigations of psychodynamic treatment for children. Numerous researchers have pointed out the dearth of studies on psychodynamic treatment for children (e.g., Kazdin, 2003; Kovacs & Kohr, 1995; Nock, 2003; Shirk & Russell, 1992; Weisz & Hawley, 1998). This scarcity is particularly problematic given that a great deal of childhood treatment provided in clinical settings is psychodynamic in nature, and it continues to be a widely used form of treatment despite the lack of evidence supporting its efficacy (Nock, 2003).

*For purposes of this discussion, child psychoanalysis, psychoanalytically oriented therapy and psychodynamic treatments will be referred to as psychodynamic psychotherapy. Although not identical approaches, they are similar in principle and practice and face common methodological challenges in outcome research (see Henry et al., 1994; Roth & Fonagy, 1996).

This is consistent with the gap between laboratory and clinical studies highlighted in Chapter 2, section 2.3.1, (e.g., Hoagwood, Hibbs, Brent & Jensen, 1995; Kendall & Southam-Gerow, 1997; Weisz, Weiss & Donenberg, 1992). Although a great deal of research has established the efficacy of various treatment interventions for children, studies have tended to focus on short-term and behavioral and cognitive/behavioral therapies involving recruited children suffering from single or less severe disorders than those seen in clinics. As a result, it is still unclear whether the optimistic findings of these studies can be generalized to child interventions as they are practiced in most clinical settings.

Kazdin and colleagues (1990) surveyed child treatment outcome in 223 studies. Over 70% of the studies surveyed were behavioral or cognitive/behavioral in nature and less than 10% were psychoanalytic, psychodynamic, client-centered or existential-humanist in orientation (Weisz & Hawley, 1998). Similarly, Barrnett and colleagues (1991) surveyed publications from 1973 onwards and found only five studies presenting traditional forms of psychotherapy. So, too, Shirk and Russell's (1992) meta-analysis highlighted the relative absence of psychodynamic therapy in child psychotherapy outcome studies and the over-representation of behavioral treatments. The few psychodynamic studies reviewed by Shirk and Russell (1992) did not demonstrate positive findings regarding the outcome of psychodynamic psychotherapy. However, the authors cautioned against the conclusiveness of these findings. The majority of non-behavioral treatments evaluated in their study had included less than twenty sessions, which is unrepresentative of normal practice. In addition, over two-thirds of the studies evaluating non-behavioral therapies had been conducted by investigators with an allegiance to behavior therapy, thus demonstrating the strong influence of investigator allegiance on the effect sizes obtained (0.17 with behavioral allegiance versus 0.56 with non-behavioral allegiance).

One of the main reasons for the scarcity of research on psychodynamic child interventions is the relative lack of long-term treatment in most outcome studies. The majority of outcome studies tend to focus on brief psychosocial interventions (Jensen et al., 1996; Miller, 2000). For obvious reasons, brief therapies are more amenable to investigation. Psychodynamic treatments, which tend to be longer-term in nature, receive less attention than short-term psychodynamically-oriented interventions (e.g., Muratori et

al., 2002). The fact that treatments offered in most clinical settings tend to be long-term further highlights the gap between interventions studied by most efficacy research and actual clinical practice. This is but one of several methodological challenges posed by psychodynamic treatment to the field of outcome research. These methodological issues are discussed in the section that follows.

3.2 METHODOLOGICAL CHALLENGES TO PSYCHODYNAMIC OUTCOME RESEARCH

Outcome research on child psychodynamic treatments is subject to the same methodological difficulties and flaws described in the previous chapter with regard to the general body of child psychotherapy outcome research (see section 2.2). In addition, psychodynamic therapies suffer from a unique set of challenges which have limited empirical attempts to evaluate their effectiveness as a treatment approach. These challenges are discussed in the following section, and recent methodological developments, despite these difficulties, are described.

a. Cultural factors

Several authors have underscored the 'cultural' factors that have inhibited systematic research in the field of psychoanalysis (i.e. Cohen, Jonathan, 1997; Target, 1993). It is not a new idea that child therapists, for the most part, are fairly unenthusiastic about research. Boston (1989), for example, lamented the traditional split between the academic researcher and the clinician in which each discipline, at best, goes its separate way - with minimal interaction between the two. Indeed, not uncommonly, each discipline actively disparages the other. Similarly, Gabbard, Gunderson and Fonagy (2002) pointed to the insignificant part that research plays in the training of psychoanalysts. Many psychoanalysts believe that their clinical work cannot or should not be evaluated empirically, and few have the type of knowledge required for systematic outcome research (Addis et al., 2000; Davidson & Lazarus, 1995; Gabbard et al., 2002; Wilson, 1995, 1996). Cohen (Jonathan, 1997) listed numerous critical facets of psychoanalysis that clinicians, on the whole, believe are not amenable to empirical study.

These include the therapist's and the patient's inner experience involving empathy, intuition, introspection, synthetic processing and the sudden and/or gradual process of insight. Although psychoanalysis originated as a science, and has employed many scientific methods and tools, the fluidity of its constructs and theories make it exceedingly difficult to study. As Cohen (Jonathan, 1997) pointed out, certain essential aspects of analytic treatment, such as the mind of the analyst and the analysand, including unconscious processes, are difficult if not impossible to operationalize (Boston & Lush, 1994).

b. Manualization of and adherence to treatment guidelines

The advantages of manualized treatments were discussed in the previous chapter (section 2.2.1.b). In particular, the ability to specify the content and stages of treatment and to ascertain that the prescribed treatment is actually being delivered is essential to outcome research. Yet, it is extremely difficult to manualize psychodynamic treatments. Target (1993) explored the lack of specification in both adult and child psychoanalytic literature and has pointed out that although the psychoanalytic literature on technique is vast, it is not written in the explicit or 'operational' terms required to define a treatment approach for effectiveness studies. Furthermore, treatment technique in psychoanalysis is guided by the analyst's judgment of subtle, often obscure, signs of unconscious conflicts, defenses and so on and is heavily dependent on the personality of the therapist and the therapeutic alliance developed with the patient. Clearly, these aspects of treatment are very difficult to capture in a treatment technique manual or scale to monitor treatment integrity (Boston & Lush, 1994). Indeed, these limitations render psychodynamic treatments less amenable to outcome research.

Despite the difficulty in manualizing psychodynamic treatments, several attempts to specify certain aspects of psychodynamic treatment in the form of a manual have been made. Two recent manuals have been developed to document and assess psychodynamic psychotherapy with children: The Hampstead Manual of Psychodynamic Developmental Therapy for Children (Fonagy, Moran, Edgcumbe, Kennedy, Target, & Miller, in press) and the Cornell Project for Conduct Disordered Children (Kernberg & Chazan, 1991). In addition, Kovacs and Kohr (1995) have referred to two additional developments: the adolescent version of the manual for interpersonal psychotherapy (see Moreau et al.,

1991) and a manual for children and parents developed by Nguyen and colleagues (1992) that combine psychodynamic and psycho-educational approaches. These manuals should make it possible to train analytically informed therapists in a relatively reliable manner, thus enabling psychotherapy outcome researchers to assess the integrity of psychodynamic treatment (i.e. the correspondence between the therapists' interventions with the stated techniques described in the manuals). If proven reliable, these manuals will have the potential to contribute meaningfully to outcome research (Foreman et al., 2000). To date, however, there have not been any psychodynamic studies conducted with the use of a psychotherapy manual (Gabbard et al., 2002). According to Cohen (Jonathan, 1997), the lack of manual-based studies raises serious methodological questions regarding all of the psychoanalytically informed studies that have been conducted up to now. So long as we do not know if therapists do what they claim to be doing we cannot know what has really occurred in psychoanalytic treatments. As a result, it is difficult to draw reliable conclusions from outcome research on psychodynamic treatments.

c. Experimental design

A third major difficulty for outcome research in this field is the choice of experimental design. The difficulties involved in implementing RCT's have been described in section 2.2.1.b. However, in the case of psychodynamic treatments, which tend to be long-term in nature, it is even more difficult to adopt the RCT approach. The major challenge is the creation of an appropriate control condition. In order to compare treated cases with untreated ones, some individuals would have to be randomly allocated to a waiting list or to a 'placebo' therapy. Although this raises ethical issues for all outcome research, it is particularly problematic for a research design that has to allow treatment to continue for years. Given that we are referring to children, withholding treatment or placement on a waiting list for prolonged periods may not only maintain their disturbance, but may actually cause greater damage to their ongoing development. In addition, children placed on waiting lists or denied treatment may turn to other treatment options at some point during the study, thus invalidating them as a non-treatment control group.

One way to avoid these ethical dilemmas is to use as the control group patients who drop out or refuse the treatment offered. This, however, raises other issues concerning the

differences between those who accept and those who reject treatment. As Kolvin and colleagues (1988) argued, dropouts may be less disturbed, or less motivated, or may have found an alternative treatment with greater personal appeal. It is equally plausible that patients who drop out of treatment or their families may be more disturbed or deviant. It therefore seems highly unlikely that dropouts are an adequately comparable group to the treated group. An alternative way to employ the RCT paradigm is to assign children to different treatment groups enabling a comparison of differing treatment modalities. This, however, raises the problem that families who were assigned to a treatment modality not of their choice may drop out of the study, thereby confounding the outcome findings and making it difficult to generalize the results. Because of these obstacles, some researchers are now advocating the use of single case study design in which individuals are assessed at baseline, prior to treatment, and then at termination and/or follow-up. In this way, individuals serve as their own control (Lush et al., 1998).

d. Outcome assessment measures

A final challenge to psychoanalytic research relates to the design of suitable outcome measures. Many outcome measures used in studies evaluating other therapies can also be applied to psychoanalytic studies (i.e. measures that assess change in symptoms). However, since psychoanalysis claims to not only reduce symptoms but to alter intrapsychic functioning and interpersonal processes as well, it is important that psychoanalytically informed measures be developed to assess the process and outcome of psychotherapy. Cohen (Jonathan, 1997) and others (Estrada & Russell, 1999; Foreman et al., 2000; Sheinfeld Gorin, 1993) reviewed several recently developed measures of this kind including: the assessment of adolescent ego functioning (Hauser et al, 1991); the quality of the therapeutic alliance (Shirk & Saiz, 1992) and defenses (Conte & Plutchik, 1995; Cramer et al., 1988); the process of therapy (Foreman et al., 2000,1996; Sheinfeld Gorin, 1993); child and adolescent representations of self and others (Tuber, 1989, 1992); and an adaptation of Luborsky and colleagues' (1994) Core Conflict Relationship Theme (CCRT) to measure transference. More recently, Estrada and Russell (1999) reported on the development of a new instrument designed to assess the process of child psychotherapy. Their measure, entitled the Child Psychotherapy Process Scales (CPPS) differs from many of the measures mentioned above in that is does not assess the subjective experience of the therapy process and is designed for use

by objective observers. Given children's developmental limitations, particularly among younger children, they are less able to comprehend the experiences of therapy. This is one of the reasons why children's evaluations of therapy have often been unrelated to their therapists' assessments (Estrada & Russell, 1999). These measures offer promising findings regarding the specific 'ingredients' of the therapeutic process that lead to intra-psychic and symptomatic change. However, some of these instruments have been used within single case design studies (e.g., Foreman et al., 2000) and need to be replicated with larger samples so that generalizations can be made. To date, relatively little research has been conducted using these measures (Estrada & Russell, 1999).

3.3 A REVIEW OF CHILD PSCYHODYNAMIC OUTCOME STUDIES

Despite the relative paucity of child outcome studies focusing on psychodynamic interventions, Cohen (Jonathan, 1997) pointed to the significant increase in psychoanalytically informed empirical research conducted in the last decade. Although the actual number of clinical studies is still small, Cohen stressed that there have been more empirical studies completed in the last decade than in the previous history of child psychoanalysis (Barrnett et al., 1991; Barrnett, 1994). In fact, in his discussion of the major developments in the field of child and adolescent psychoanalysis in the past fifteen years, Cohen (Jonathan, 1997) argued that the increase in systematic and empirical research is the single most important development. In this section, a brief review of the psychodynamic outcome studies to date is presented. As will be seen, these studies vary in their target populations, clinical settings, and treatment modalities. Particular emphasis is given to the Anna Freud Centre retrospective study of child psychoanalysis which forms the basis for this dissertation.

The Heinicke Studies

Heinicke (1965) conducted one of the earliest studies of child psychoanalytic psychotherapy among a small sample of children with learning problems linked to psychological disturbances. The children had received psychoanalytic psychotherapy, either one or four sessions per week. Heinicke reported greater improvement in the group receiving more frequent therapy. However, it must be noted that although the

study represented an important first step in child psychoanalytic research, it suffered from several methodological difficulties. First, the population was poorly characterized. Second, the therapy was described only as analytically oriented and delineated only in terms of frequency of sessions. Third, outcome assessments were comprised of non-standardized interviews and intelligence, achievement, and projective psychological testing. Finally, the study did not include a measure of reliability for the interpretative tests.

In a later study, Heinicke and Ramsey-Klee (1986) examined a group of pre-adolescent boys who presented with academic failure. Again, high and low frequency (four sessions or one session per week) treatments were compared for efficacy. In addition, a third group seen once a week for a year and then four times a week was also included in the study. Their results demonstrated that children seen most frequently showed more positive gains in all domains, including capacity for relationships, frustration tolerance, and ability to work. The change in capacity for relationships and flexible adaptation were seen most dramatically one year after treatment termination. However, this study too did not specify the nature of the treatment offered, nor was there an attempt to explain what it was about increased frequency that led to greater improvement.

The Anna Freud Centre Diabetes Studies

A set of psychoanalytic studies conducted at The Anna Freud Center (AFC) focused on children presenting with brittle diabetes. The studies first explored the effectiveness of high frequency psychoanalytic treatment and then examined the relationship between therapeutic process and metabolic control in children with very poorly controlled diabetes. In the first study, Moran and Fonagy (1987) looked at the relationship between metabolic control and the process of psychoanalysis in a single case study of a diabetic adolescent girl. Process reports were rated for the presence of dynamic themes (symptomatic and conflictual). The authors examined the association of these themes with independently obtained measures of diabetic control using time-series analysis. The authors demonstrated a close statistical relationship between week-to-week fluctuations of metabolic control and the presence of key themes in the patient's analytic material. Most significantly, the analytic narrative predicted the child's subsequent diabetic control: the presence and interpretation of unconscious emotional concerns in the therapeutic process was reliably followed by an improvement in diabetic control one to

three weeks later. These finding would seem to suggest that psychological and biological processes are interrelated.

In the second study, Fonagy and colleagues (1989) compared two equivalent groups of eleven diabetic children with grossly abnormal blood glucose profiles requiring repeated hospitalizations. Patients in the treatment group were offered an intensive in-patient program that included three to four times a week psychoanalytic psychotherapy for an average of fifteen weeks. Patients in the control group were offered standard in-patient medical treatment. Patients in the treatment group showed considerable improvement in diabetic control, maintained at one-year follow-up. In contrast, the children in the control group returned to pre-treatment levels of metabolic control within three months of discharge from hospital.

The third of these studies (Fonagy & Moran, 1990) entailed an independent series of experimental single case investigations into the impact of psychodynamic treatment on growth rate (e.g. changes in height and bone age) in three children whose height had fallen below the fifth percentile for age. In all three cases, therapy was associated with an acceleration of growth and a substantial increase in predicted adult height. Target (1993), in her review of these studies, highlighted the way in which these studies demonstrate an important method for verifying the clinical efficacy of psychoanalysis. According to Target (1993), the crucial components of these studies' research approach are: 1) a readily definable client group which tends to respond poorly to alternative treatments; 2) a clinically relevant outcome variable which is robust to contamination from the treatment process; 3) complementary process studies which offer suggestive evidence of the effective component of the treatment. The methodology of these studies was strong in two respects: inclusion and exclusion criteria were stated clearly and the integrity of the therapy was well maintained. Although two of the studies used control groups, placebo groups were not included, thereby avoiding the ethical dilemma of assigning patients to experimental conditions where no therapeutic yield is expected.

The Tavistock Clinic Adoption and Foster Care Studies

The Tavistock Centre has also been involved in the study of the efficacy of psychoanalytically informed child psychotherapy. Lush, Boston and Grainger (1991) compared 35 children in psychotherapy who were fostered or adopted with 13 similar

children for whom psychotherapy had been recommended but did not start. The treatment group was comprised of children ages two to 18 years; over half were girls, and most received weekly sessions for at least one year. The study was naturalistic, and measures were developed specifically for the study without evidence of established reliability or validity. However, there are some indications that psychotherapy did benefit the majority of these (mostly) deprived children. Preliminary results on the first 20 children to be treated found that 16 of the 20 children made 'good progress' as judged by therapists' ratings and confirmed in most cases by parents' and external clinicians' opinions. An informal comparison was made with seven similar (but not matched or randomly assigned) children who were regarded as suitable for therapy, but did not receive it for external reasons; none of these children had improved during the same period. A second stage of the project (Lush, Boston, Morgan & Kolvin, 1998) followed-up some of the subjects six months and one year after they had concluded treatment. The authors presented a single case study in which, according to the therapist, the adopted child had continued to improve, both emotionally and generally, thereby supporting the 'sleeper effect' phenomenon.

A study of time-limited versus time-unlimited psychodynamic treatment

Smyrnios and Kirkby (1993) compared the therapeutic effects of psychodynamically-oriented therapy with thirty latency age children. Their findings did not, however, support the efficacy of psychodynamic therapy with children. Subjects were divided into three groups, each comprised of ten children: 1) one group received 'time-unlimited' therapy (on average 28 sessions, with a range of 3 to 62 sessions); 2) one group received 'time-limited' sessions (on average 10.5 sessions, with a range from 5 to 12 sessions); and 3) one group was assigned to a minimal contact group. The authors found that all three groups showed significant improvements from pre-test to post-test on a number of individual and family ratings. In addition, comparisons between groups at post-test, and at a four year follow-up, on a parental measure of family functioning, showed that changes reported by the minimal contact group were significantly greater than those of the unlimited therapy group. However, only the minimal contact group reported significant improvement on severity of target problems and measure of family functioning. These results seem to suggest that long-term therapy does not necessarily provide effective therapy. In fact, in this study minimal therapy appeared to be the most effective.

Cohen (Jonathan, 1997), in his review of this study, pointed out several of its strengths. The study included clear inclusion and exclusion criteria; it strived to develop a methodologically sound matched control group, and its outcome measures were standardized assessment and valid behaviorally based tools. However, the study did not include an outcome evaluation that was particularly psychoanalytically based. More importantly, the study did not specify the nature of the 'time-unlimited' therapy (i.e., what was the nature of the dynamic therapy, how often were the children seen, etc.). Echoing the researchers cited above, Cohen argued that time-unlimited psychodynamic therapy of an average of 28 sessions is not in accord with usual clinical practice, thus limiting the generalizability of these results.

The Austen Riggs Center Study

Blatt and Ford (1994) evaluated psychoanalytically oriented long-term treatment (hospitalization and four times a week psychoanalytic psychotherapy) of a group of adolescents and young adults at the Austen Riggs Center in America in Target, 1993. Patients were administered a set of behavioral and psychological measures (projective and cognitive tests) at the beginning of their hospitalization and fifteen months later. The findings indicated several impressive changes on the independently assessed psychological and behavioral measures fifteen months after onset of treatment. These included: decreased frequency and/or lessened severity of clinical symptoms, better interpersonal relations, increased intelligence, decreased thought disorder and decreased fantasies about unrealistic interpersonal relations. A follow-up of these patients over thirteen years later seemed to demonstrate sustained significant general adaptation since discharge from the hospital (Plakun et al., 1985). Although this study included systematic and methodologically sound procedures for measuring pre/post changes and outcome that assured the independence of various ratings, the specific nature of the psychotherapy provided was not delineated. In addition, there was not a randomized comparison of treatments. Most significantly, it remains unclear whether the positive findings are the result of the high-frequency psychoanalytic treatment and/or of other aspects of the hospital treatment program.

A study of a community mental health center for youth (USA)

A recent study conducted by Dalton and colleagues (2000) assessed the effectiveness of mental health treatment offered to children ages 5-12 presenting with moderate to severe mental health problems. This study was conducted in a naturalistic clinical setting and included a control group taken either from a dropout list of children who had completed the evaluation process but who rejected treatment, or were recruited from therapy waiting lists. In order to assess treatment effectiveness, the Child Behavior Checklist (CBCL) was administered to parents before and after treatment. Based on their findings, the authors reported that children receiving treatment significantly improved on both the externalizing and internalizing CBCL scales as compared to the control group. Although the findings seem to support the effectiveness of treatment, the authors do not specify what type of treatment the children received other than general categories of 'psychotherapy' (including two sub-groups – with and without drug treatment), and 'pharmacotherapy-only. In addition, the study did not include a follow-up investigation after treatment termination. As a result it is impossible to know whether the reported treatment gains were maintained over time.

A study of a community mental health centre for adolescents (UK)

Baruch and Fearon (2002) reported recently on a community-based evaluation of treatment outcome for adolescents (ages 12-18 years) who received psychodynamic psychotherapy at the Brandon Centre in London. The authors investigated the treatment outcome of 151 adolescents who completed a self-report form at intake, three months, six months, one year, and a one-year follow-up. Interestingly, the authors found that while most individuals tended to improve, the rate of improvement dropped significantly over time. Indeed, psychotherapy in this sample seemed to be most effective in the first six months of treatment, perhaps because treatment at this stage focused on the patients' symptomatic difficulties. The authors suggested that perhaps after six months the patients' more deeply rooted problems (such as personality and interpersonal difficulties) begin to emerge as the focus of treatment – problems which are much more difficult to treat successfully. This study represents an important attempt to grapple with the difficulty of evaluating community-based treatment in a naturalistic setting and it provides clear descriptions of its treatment modalities. It does not, however, include a control group and, as such, limits the generalizability of its findings.

A study of brief psychodynamic psychotherapy

Muratori and colleagues (2002) presented a recent study investigating brief psychodynamic psychotherapy (BPP – with a maximum of eleven weekly sessions over roughly four months) for children with emotional disorders. In their study, thirty children between the ages of six and ten years were evaluated at the beginning of treatment, after six months, and at an eighteen month follow-up. Despite a small sample size and the lack of randomized assignment to treatment or control conditions, the sample appears to have been representative of a typical clinical sample in terms of both the heterogeneity of presenting problems (dysthymia, anxiety and oppositional defiant disorder) and the high frequency of comorbidity among clinical samples. In addition, it had clear inclusion and exclusion criteria, a manual-based therapeutic model, and a control group. Half the subjects (fifteen) were assigned non-randomly to the control group, meaning they did not receive BPP or any other forms of treatment in the community. Because of the short-term nature of the intervention, ethical concerns regarding the postponement of treatment were relatively minor. The authors reported that children who received BPP showed better improvement than the control group. Interestingly, at six months the experimental group demonstrated better improvement in global functioning, as assessed by the Children's Global Assessment Scale and CBCL, than the control group. At follow-up, eighteen months after treatment commenced, both groups had improved to a comparable degree, but only the mean of the experimental group had moved into a functional range. Based on these findings, the authors concluded that BPP not only produces a reduction in problems in the short-term, but also evidences the so-called 'sleeper effect', leading to improvement in the long–term as well. Clearly, replication of these findings within a larger sample size is important, however the study offers an example of how systematic empirical investigations, using short-term psychodynamic interventions, can be carried out in a methodical and rigorous manner.

The Anna Freud Centre Retrospective Study of Child Psychoanalysis

Perhaps the most comprehensive clinic-based study of the efficacy of long-term psychoanalytic treatment for children is that conducted at The Anna Freud Center (AFC) by Fonagy and Target (1996). The study took the form of a retrospective chart review in which the files of 763 children and adolescents treated at the AFC over the previous forty years were reviewed. Overall, the study found that high-frequency treatment (four or five sessions per week) as opposed to low-frequency treatment (one to three sessions per

week) was significantly helpful for children presenting with severe and pervasive disorders.

The study (Target and Fonagy, 1994b) first explored the effectiveness of psychoanalytically informed therapy for 352 children with emotional disorders (i.e. DSM-III-R diagnoses of anxiety or depressive disorders). Two hundred and fifty-four children were treated in full psychoanalysis, and the remainder received one to three sessions per week, for an average of two years. Children's overall levels of adjustment were assessed at the beginning and end of treatment using the Hampstead Child Adaptation Measure (HCAM). The HCAM was designed to assess a child's prosocial functioning as well as impairment. However, impairment is not measured primarily in terms of psychiatric symptoms or diagnoses but rather by level of adaptation and ability to function in appropriate ways. The manualization of the HCAM was based on the Health-Sickness Rating Scale (HSRS, Luborsky, 1962) and the Children's Global Assessment Scale (CGAS, Shaffer et al., 1983). The scale was also influenced by Anna Freud's developmental lines (A. Freud, 1963) and an adult measure of structural change devised by Wallerstein and colleagues (Wallerstein, 1988). The HCAM is a 100-point scale with anchor points at ten-point intervals. Scores above 70 represent functioning within the normal range, scores below 30 reflect severe impairment, probably requiring hospitalization, and scores between 30 and 55 most likely indicate the need for therapeutic assistance and, often special education needs. Ratings are based on 15 operationalized parameters of functioning (see Appendix 3.1) relative to the child's age, physical condition and social circumstances. In order to assist ratings, the HCAM manual provides case examples taken from the files of actual AFC patients for each ten-point interval.

Using the HCAM as the main indicator of treatment outcome, the study demonstrated the following results: 1) 72% of those treated for at least six months showed reliable, clinically significant improvement in adaptation, only 24% had a diagnosable disorder at termination, and 15% still had an emotional disorder; 2) simple phobic disorders were most likely to remit, and depressed children least likely to return to normal CGAS levels; 3) Children under eleven years were considerably more likely to be well at the end of treatment; 4) length of treatment was associated with outcome, and high frequency treatment led to greater improvement independent of the child's age and treatment length;

5) high frequency treatment was significantly more helpful for children who presented with severe disturbance, in terms of multiple diagnoses or CGAS scores below 45.

In addition, a number of demographic and clinical variables helped to identify children most likely to improve. These included: higher IQ, younger age, longer treatment, good peer relations, poor overall adjustment of the mother, the presence of anxiety symptoms in the mother, concurrent treatment of the mother, and absence of a history of maternal antisocial behavior. Groups of children with depressive, overanxious and specific anxiety disorders had different predictors of favorable outcome, underscoring the heterogeneity of this group and the different processes at work in their psychotherapeutic treatment.

In the second part of the chart review, the efficacy of psychoanalysis with children with disruptive disorders was examined (Fonagy & Target, 1994). One-hundred and thirty-five children with a principle diagnosis of disruptive disorder were individually matched on demographic, clinical and treatment variables with other children suffering from emotional disorders. Overall, improvement rates were significantly lower for the disruptive than the emotional group. Within the disruptive group, significant improvement was more frequent among children with oppositional defiant disorder (56%) than those with attention deficit hyperactivity disorder (36%) or conduct disorder (23%). However, 31% of the disruptive children terminated treatment within one year of starting therapy. Of those disruptive children who remained in therapy for more than one year, 69% were no longer diagnosable on termination. For children with disruptive disorders, predictors of improvement included: the presence of an anxiety disorder, absence of comorbidity (particularly developmental disorders), younger age, intensive treatment, longer treatment, maternal anxiety disorder, child having been in foster care, and psychotherapeutic treatment of mother.

The final report of this chart review focused on developmental issues (Target & Fonagy, 1994b). The review examined the way in which the age of the child or adolescent in treatment was related to treatment outcome. One hundred and twenty-seven children were selected from three age bands (under 6, 6-12, and adolescents); they were matched on broad diagnostic grouping, gender, socio-economic status, HCAM score, and frequency of sessions. Outcome was indicated by diagnostic change and clinically

significant change in adaptation. The authors found that younger children generally improved to a greater extent, and children under twelve benefited more from high than from low frequency treatment. This, however, was not true of adolescents. The results seem to indicate that in analytically oriented therapy, younger age is an advantage and that developmental factors (e.g. age and level of functioning) considerably affect the outcome of psychotherapy.

Although retrospective studies suffer from a range of methodological limitations (i.e. the use of records of uneven quality, not recorded with relevant variables in mind, using non-standardized assessment procedures and with areas of missing data which may not even be possible to identify; impossibility of randomly allocating subjects), they do enable the assessment of a much larger number of cases than could be included in a prospective study, and permit the provisional identification of variables related to outcome, generating hypotheses which can then be more rigorously tested prospectively. The AFC chart review was methodologically well designed. The authors described a high degree of therapy integrity maintained with all subjects, standardized diagnoses were made with high reliability of judgments, standardized rating instruments were used to record symptom profiles and outcome, and low and high frequency groups were matched across several variables. In light of these many methodological strengths, Cohen (Jonathan, 1997) described this study as reflecting a very important step forward in the assessment of psychoanalytically informed psychotherapy.

3.4 THE LACK OF FOLLOW-UP STUDIES IN OUTCOME RESEARCH

A final concern relevant to all outcome research, but of particular relevance to the long-term effectiveness of childhood interventions, is the general lack of follow-up assessments. Most outcome studies on child psychosocial interventions do not include long-term follow-up assessments (Fonagy et al., 2002; Jensen et al., 1996). According to Kazdin (1991), approximately 40% of child and adolescent outcome studies have included follow-up assessments. Although Weisz and colleagues have presented meta-analyses showing durable treatment gains, these conclusions were drawn from studies with an average follow-up of 4-6 months (Weisz & Weiss, 1993). Indeed, the few

studies that include follow-up assessments rarely extend beyond six months (Brestan & Eyberg, 1998; Kazdin et al., 1990), although some continue to 18 months (e.g., Hamner et al., 1997; Muratori et al., 2002).

The need for long-term follow-up assessment

The need for follow-up assessment has been recognized for decades and calls for its inclusion in psychotherapy outcome research have been called for repeatedly (e.g., Heinicke & Strassman, 1975; Kazdin, 1991; Levitt, 1957; Robins, 1974; Rutter, 1982; Wallerstein, 1992; Wright et al., 1976). As early as 1957, Levitt found that treated children continued to improve at least some months after the end of treatment, indicating that comparisons between treated and untreated children may look very different depending on the point of assessment. Several studies demonstrated the fact that conclusions regarding the efficacy of treatment are very often a function of when the outcome is assessed. One notable example is an early study conducted by Kolvin and colleagues (1981) in which several school-based treatments for emotional and disruptive disorders in children were evaluated. At termination, it seemed that group therapy or behavior therapy had not yielded significant improvements on measures of neuroticism, antisocial behavior, and total symptom scores. However, at an eighteen-month follow-up, children in both the group therapy and behavioral therapy conditions had improved markedly on the above measures as compared to children in the other treatment and control conditions. Based on these results, the authors discussed a 'sleeper effect' in which improvements that are not evident immediately after termination of treatment emerge and/or increase over time. Similarly, several studies involving both child and adult subjects have demonstrated that the treatment that appeared more or most effective at termination does not necessarily maintain that status at follow-up (Hechtman, 1996; Kazdin, 1991; Wright et al., 1976).

Increasingly, researchers have been calling for follow-up assessments. Weiss (1998a, 1998b) suggested that children be assessed minimally on three occasions – at the beginning of treatment, at termination, and at follow-up, several months to a year after the conclusion of treatment. Similarly, Pfeiffer (1989) has recommended at least two follow-up assessments, one at six months and one at twelve to eighteen months after treatment termination. In the case of children, the importance of long-term follow-up is essential. Indeed, lately, researchers have been stressing the need for follow-up studies

that cover a period of *years* after treatment termination (Eyberg, Edwards, Foote & Boggs, 1998a). Short-term follow up does not necessarily provide information on the durability of improvement or change due to treatment. Fonagy and colleagues (2002) suggested that, in the case of children, even impressive gains may not be maintained because of the possible influence of negative transactional processes. Given that children are in the midst of ongoing developmental processes, it is likely that the interplay between therapy and cognitive and emotional change may not be evident at the end of treatment but rather will express itself at a later time. Judging treatment outcome only at termination can generate misleading conclusions (Kazdin, 1991; Weisz & Hawley, 1998). It therefore seems imperative to conduct long-term follow-up using a life-span perspective in order to accurately assess whether treatment in childhood not only leads to immediate gains but, more importantly, to lasting benefits. According to Fonagy and colleagues (2002), all childhood interventions regardless of theoretical orientation contain a preventative component. Even those treatments that focus solely on symptom reduction aim to help children rejoin a normative developmental path, thereby helping to prevent later risk and disturbance. As such, assessing the effectiveness of child treatments, without including a long-term follow-up component, overlooks a critical treatment goal.

Long-term follow-up of child psychodynamic treatments

The inclusion of long-term follow-up assessments in psychoanalytic outcome research has an even poorer track record than that of the non-psychodynamic therapies (Buckley et al., 1984; Wallerstein, 1992; Bergin & Garfield, 1994). Bachrach and colleagues (1991) surveyed psychoanalytic studies and found that only two offered sufficient long-term data regarding the individual nature of change to be informative from a psychoanalytic point of view. The two studies cited were the Wallerstein (1986) Menninger project and the Kantrowitz (Kantrowitz, Katz, & Paolitto 1990) Boston Institute project. Although both studies had relatively small sample sizes, they demonstrated the feasibility of systematically planned follow-up of analytic cases and yielded a great deal of information relevant to the theory and practice of psychoanalysis. Particularly of note is the Menninger study in which the researchers collected extensive and detailed information from a number of sources covering several domains of functioning (such as psychiatric, personality, and social adaptation), and process measures of treatment. Both these studies included adult populations, and there is no

comparable information in the literature concerning the long-term effects of child and adolescent psychoanalytic treatment (Target, 1993). Given that psychodynamic treatment not only aims to reduce symptomatology but also to enhance resilience (Fonagy & Target, 1996), the dearth of long-term assessments is critical, particularly within the current demands for accountability

Broadening follow-up studies to increasingly longer time periods raises a host of methodological and interpretive difficulties, and it is with good reason that researchers have shied away from conducting long-term follow-up assessments. Perhaps first and foremost, long-term follow-up studies are expensive to conduct both because of their multiple assessment stages and the frequent need to trace previous patients who may have moved far away from their original homes, sometimes long-distance and even internationally. Contacting adults who were treated in childhood but who may have no recollection of having done so raises certain ethical issues as well. Psychoanalysts, in particular, have shied away from initiating contact with former patients on theoretical grounds (Waldron, 1997). However, there is evidence that so-called 'booster sessions' (Nock, 2003; Weisz & Hawley, 1998) may prevent the 'slippage' of treatment gains and it is possible that follow-up sessions alone, at least in the initial period following treatment termination, may help to preserve positive outcome in light of the transactional pressures to which children are subjected.

In addition to these concerns, the longer duration of follow-up studies increases participants' attrition rates. Interpreting the meaning of subjects who drop out from the study at various stages introduces a host of ambiguities. Although Cox and colleagues (1977) found that subjects who do not continue to take part in follow-up studies tend to be more impaired than those who do, it is not clear that this is always the case. A further difficulty related to long-term follow-up studies is that the greater the time that has elapsed from treatment termination to follow-up, the more difficult it is to attribute change or durability of immediate outcome to the original treatment intervention. Obviously, a vast number of other variables impinge upon the individual, and in 'real world' studies it would be impossible to control adequately for this degree of variance. Furthermore, over time individuals may seek out additional treatment of one kind or another, and it would be extremely difficult to interpret whether and to what extent later treatment strengthened, weakened or changed the original treatment's effects. A final

difficulty posed by longitudinal studies relates to finding an appropriate control group willing to participate in a long-term follow-up study that may take place over years.

3.5 CONCLUSIONS

Although research on the outcome of child psychodynamic psychotherapy has developed considerably in the last ten to fifteen years, current findings are still inconclusive and, at times, even contradictory (Henry et al., 1994). Most non-randomized studies of traditional psychotherapy have not demonstrated its effectiveness (Weiss, 1998a, 1998b). Indeed, in two recent studies, traditional treatment and academic tutoring were found to be similarly helpful in reducing psychopathology (Weiss, Catron & Harris, 2000; Weiss, Catron, Harris & Phung, 1999). Furthermore, most psychodynamic treatments have not been tested empirically, and those that have been studied have failed to support the effectiveness of this form of treatment for the most part (see Baruch and Fearon's review, 2002). This state of affairs is particularly problematic given that the most common form of treatment offered by clinics continues to be psychodynamic. In the last 15 years, the outcome of psychodynamic treatment in childhood has received increasing and more methodologically sophisticated attention. However, the effectiveness of psychodynamic treatment has not yet been proven. The long-term nature of most psychodynamic therapies requires greater resources than briefer forms of treatment. It is, therefore, expected that in the current 'age of accountability,' the effectiveness of psychodynamic interventions will come under increasing scrutiny.

Future outcome research needs to address not only the general question of whether or not psychodynamic interventions in childhood lead to treatment gains, but whether it is equally effective (or ineffective) for all types of disorders. Taking into account developmental issues, future research should also address whether psychodynamic treatment is best suited for all age groups or if, for example, there are particular interactions between type of disorder and developmental stage that are best addressed by this form of treatment. At the same time, it is important to compare psychodynamic treatments to other forms of therapeutic intervention to see whether they lead to similar levels of improvement across a range of clinical problems both at post-treatment and in

the long-term. Finally, in light of the aim of psychodynamic treatments to restore children to a normative developmental path and to enhance their resilience in the longer term (Boston & Lush, 1994), outcome research needs to give special attention to long-term follow-up assessments of treatment outcome. Follow-up research is essential in order to evaluate whether post-treatment gains are maintained over time and, thus, whether treatment can truly be considered effective, thereby justifying the often lengthy and costly aspects of psychodynamic treatment. Outcome studies should include follow-up assessments for as long a period as is practical and with special reference to the natural history of particular disorders. Thus, for example, children treated for depression need to be followed up for some years, ideally into adulthood, as the disorder tends to remit spontaneously and then recur (Target & Fonagy, 1996). So, too, given the interplay between maturation and change, the need for follow-up research in child and adolescent psychotherapy is particularly crucial.

Although long-term follow-up research poses a host of formidable methodological difficulties, none of them amenable to easy solutions, there seems to be a general consensus among researchers regarding its importance. The following chapter presents a long-term follow-up study of adults who were treated in childhood at the Anna Freud Centre. To the best of our knowledge, it represents a first attempt to investigate the long-term effects of psychoanalytically oriented treatment in childhood, and demonstrates many of the methodological challenges inherent in research of this kind. As such it serves as an important first step in the development of long-term child psychodynamic outcome research.

CHAPTER 4. THE ANNA FREUD CENTRE LONG-TERM FOLLOW-UP STUDY

This chapter introduces a long-term follow-up study of children treated at the Anna Freud Centre (AFC) in London between 1952 and 1991. The study is based on the AFC retrospective chart review study of child psychoanalysis described in section 3.3. It follows on from the chart review by tracing the patients whose file summaries formed the data for the chart review in an attempt to see where they are today and how they are functioning in adulthood. The study uses a "catch up" methodological design in which childhood data is assessed retrospectively through the use of case files, and in which adult data is assessed by 'catching up' with former patients who undergo extensive interviewing in adulthood (see Brieger et al., 2001; Weiss, 1996). The follow-up study has several central aims. First, the study assesses the adult outcome of a group of high-risk disordered children. Second, it examines the extent to which psychotherapeutic intervention in childhood mitigates the expected negative life trajectories of children diagnosed with early psychological disturbances. Finally, the study aims to explore some of the mechanisms that help an individual to develop from a dysfunctional state to a more adaptive one, alongside some of the potential moderators that interact with these mechanisms, ultimately leading to differential therapy outcomes. The chapter concludes with a description of the follow-up subjects' childhood background in relation to the larger retrospective study sample from which they were drawn.

4.1 THE BACKGROUND TO THE LONG-TERM FOLLOW-UP STUDY

4.1.1 The long-term outcome of child psychopathology

Evidence from epidemiological studies, as presented in section 1.1, underscores the relatively high prevalence of psychiatric disorders among children and adolescents (e.g., Bird, 1996; Burns et al., 1995; Costello et al., 1996; Roberts et al., 1998; Verhulst & Achenbach, 1995). Although estimates vary, the data overwhelmingly suggest that early

psychological disturbance needs to be addressed by mental health professionals in order to mitigate the suffering of children and their families and to prevent the negative emotional, cognitive and social consequences of childhood disorders. What makes the prevalence figures all the more worrying are the recent findings of longitudinal studies (e.g., Kim-Cohen, et al., 2003) on the natural history of childhood disorders. Overwhelmingly, the evidence from these studies demonstrates that most children do not, as once believed, grow out of their difficulties. Instead, as presented in section 1.2, many disorders persist into adolescence and adulthood, although symptomatology may undergo significant change. Externalizing disorders such as Conduct, Attention Deficit Hyperactivity and Opposition Defiant Disorders have a particularly poor track record, leading to widespread maladjustment in adulthood (Campbell, 1995; Farrington, 1995; Lahey et al., 1995; Offord & Bennett, 1996; Robins, 1986). In many cases, the negative outcome of early disturbance expresses itself in far-reaching social and emotional impairment (Fonagy et al., 2002; Weissman et al., 1999). This is displayed in higher rates of mental health and medical service use, difficulties in academic and vocational achievement, and poor social functioning (Hechtman, 1996; Kane & Kendall, 1989; Keller et al., 1992; Popper, 1993). Taken together, the findings from these studies indicate that disordered children remain vulnerable to pervasive and, often, life-long impairment.

In addition to early childhood disorders, researchers have highlighted a range of environmental and individual factors that are known to place children at risk for later adult maladjustment (see section 1.3). A unique study conducted by Champion, Goodall and Rutter (1995) found that adversity in adulthood was strongly associated with poor planning abilities for major life transitions. In their study, 228 individuals between the ages of 10-11 were followed up twenty years later. Subjects were asked about the stressors they had experienced in adult life in the five years preceding the interview, their coping strategies, and their ability to navigate transitions in several domains (intimate relationships/parenting, work/education, and independent living). The authors reported a strong association between emotional and behavioral disturbance in childhood and a marked increase in the rate of severely negative life events and difficulties in adulthood, particularly those associated with onset of adult psychiatric disorders. These negative events could not be accounted for by adult psychiatric disorder, the participants' behavior or continued association with family of origin. Instead, poor planning, particularly at

transition points, was found to be an important reason underlying the increased number of severe life events (Rutter, Champion, Quinton, Maughan, & Pickles, 1995). These findings suggest that a person's behavior in childhood contributes powerfully to the experience of a high rate of stressors and adversities in adulthood that, in turn, put them at greater risk for psychiatric disturbance in later life.

4.1.2 The long-term impact of child psychotherapy on adult functioning

In light of these findings, mental health professionals and public policy makers need to ask themselves how the long-term adult consequences of childhood disturbance and adversity can be forestalled. Psychotherapeutic interventions in childhood clearly aim at relieving distress and symptomatology. Indeed, research on the outcome of childhood psychotherapy supports the conclusion that, in general, childhood treatments are effective (Weisz & Hawley, 1998; Weisz et al., 1998). However, as described in sections 2.3 and 2.4, most outcome studies are laboratory based and, as such, are unrepresentative of the therapists, treatment techniques, and complexity and severity of disorders that are typical of patients in clinical settings (Dodge, 2001; Hoagwood & Hibbs, 1995; Peebles, 2000; Weisz et al., 1998). This severely limits the ability to generalize findings from outcome studies to clinical samples and underscores the need for naturalistic studies. Furthermore, due to the predominance of meta-analytic studies in outcome research (see section 2.2.1), we do not yet have a clear picture as to what types of interventions are best suited to specific disorders (Beutler, 2002; Chambless, 2002; Klein, 2002; McCullough, 2002; Schneider, 2002).

The AFC retrospective study described in section 3.3 addresses some of the above limitations in that it is based on a naturalistic setting and explores the relative strengths of child psychoanalysis and psychoanalytically oriented therapy (under-represented in outcome studies, despite the prevalence of the latter in clinical practice) for both internalizing and externalizing disorders. However, very few of the outcome studies to date provide us with information regarding the long-term impact of child psychotherapy on future development. Given the negative life trajectory associated with childhood disturbances, it is imperative to examine whether interventions that bring relief to childhood disturbance in the short-term continue to affect longer-term functioning.

Child psychoanalysis places great emphasis on the correction of developmental anomalies which are perceived to underlie symptomatology, with the goal of preventing long-term social and emotional impairment (Boston & Lush, 1994; A. Freud, 1965; Kennedy & Moran, 1991). In this sense, child psychoanalysis is perceived as serving a preventative function by returning a child to a path of normal development (A. Freud. 1965).

The long-term follow-up study presented in this chapter was designed in order to examine treatment impact across the life span into adulthood. In particular, the study aims to investigate whether or not gains achieved through psychotherapy in childhood are maintained over time or undergo change into adulthood. Various patterns are possible. Patients who benefited from early treatment may continue to develop in a healthy and functional manner; alternatively, treatment gains may be transient and future development may be associated with similar or different forms of psychosocial disturbance in keeping with the findings on the natural history of childhood disorders. In contrast, patients who did not seem to benefit from treatment at the time of termination may continue to suffer from psychological disorders throughout adolescence and into adulthood. However, it is also possible that assessing them later in life may demonstrate that, post-treatment, these individuals turned into well-functioning individuals, possibly as a result of early intervention, thus pointing to the so-called 'sleeper effect' phenomenon. This long-term perspective is in keeping with a developmental approach that recognizes that therapists treating children meet them at a fluid time in their lives, when they are in the throes of development.

In this era of accountability (Moos, Nichol & Moos, 2002; Parry & Richardson, 1996l Peebles, 2000), in which treatment providers are increasingly required to justify the cost of their services, the long-term perspective provided by the follow-up study may shed important light on the cost effectiveness of intensive childhood interventions on later development. As described in section 1.2, longitudinal research clearly points to a poor long-term prognosis for disordered children. If adults treated in childhood turn out to require fewer medical and psychological treatments in adulthood, and to lead relatively unimpaired lives, the importance of therapeutic investment in childhood will be convincingly demonstrated. Indeed, such evidence would justify the view of early treatment as a preventative intervention for later psychosocial disturbance.

4.1.3 Mechanisms and moderators of individual change

Despite evidence on the effectiveness and efficacy of various childhood interventions (Target & Fonagy, 1994a, 1994b, 1994c; Weisz et al, 1998), very little is known about how or why psychotherapy actually leads to change (Nock, 2003). Even less is known about the therapeutic factors that impact on long-term and enduring changes. From a psychodynamic perspective, continuity between childhood and adulthood is conceived as related to the ongoing influence of an internal mental representational system, established in childhood, which continues to organize an individual's relationship patterns in consistent ways across a range of social settings. In keeping with this perspective, psychotherapy is perceived as a process through which mental representations are modified, thereby preventing the repetition of early negative relational patterns over time. By helping an individual to overcome early adversity, these internal changes can lead to healthier relationships and to a fuller realization of cognitive, social and emotional potential. According to Fonagy and colleagues (1994, 1997) an essential element of the psychoanalytic process relates to the enhancement of psychological resilience through the development of reflective functioning. The authors define reflective functioning as the ability to mentalize productively on the psychological states of self and other. This capacity has been found to reduce the likelihood of intergenerational transmission of insecure attachment (Fonagy, 1997). Given that an insecure attachment status is an important risk factor for the development of psychiatric disorder across the life span (Cole-Detke & Kobak, 1996; Cyranowski, Bookwala, Feske, Houck, et al., 2002), enhancing reflective functioning and security of attachment through psychoanalysis may represent an important protective mechanism.

One of the vexing issues facing clinicians is the fact that individuals do not respond uniformly to treatment. How, then, are we to understand why two individuals who present with the same symptoms of comparable severity and tenacity complete treatment with different outcomes and go on to develop in differing ways. In an attempt to better understand this phenomenon, the follow-up study also aims to explore the relationship between a range of childhood variables (including family background, individual characteristics and treatment variables) and adult outcome. The interaction between these variables and treatment mechanisms may shed additional light on individual responses to treatment. This latter subject will be taken up in Chapter 6.

4.2 DEVISING AN INTERVIEW PROTOCOL

During the initial stage of the follow-up study two parallel processes took place. The first process involved the compilation of a core battery of outcome measures that, in keeping with psychodynamic theory, would assess adult functioning not only in terms of psychopathology and psychiatric disturbance, but also in terms of functioning across multiple domains. The second process related to the identification and tracing of potential subjects for participation in the study. Although both processes took place in parallel, they will be described in separate sections for purposes of clarity.

4.2.1 Compiling a battery of adult outcome measures

As mentioned in Chapter 3, the relative lack of studies that follow up treated children into adulthood, particularly with regard to psychodynamic therapy, necessitated the creation of a battery of adult outcome measures. It was important to develop a comprehensive battery of adult outcome measures that could provide valid and reliable data on the one hand and, at the same time, remain consistent with psychodynamic concepts that view an individual's functioning across a broad range of developmental tasks. We therefore assembled a group of outcome measures to cover the following key areas of adult adjustment: psychopathology and use of mental health services since treatment; physical health and use of medical services in adulthood; personality functioning across a range of domains; attainment of developmental tasks (e.g., separation from parents, establishment in work, creation of intimate adult relationships); quality of relationships, including attachment status; coping skills; planning for transitions; stressors and adversity across the lifespan. This comprehensive assessment protocol is in keeping with recommendations for multi-levels assessments presented in section 2.5 (Fonagy, 1997; Hoagwood et al., 1996). Thus, a subsidiary goal of the follow-up study was the development of a battery of adult outcome measures relevant to psychodynamic outcome research filling a current void in the field.

For the most part, the study incorporated existing measures into the interview protocol, with the exception of the coping measure that was developed by the author (see Impact of Stress below, section 4.2.2.b.3). Many of the measures come from a family of

psychometric instruments pioneered in the United Kingdom by professors Michael Rutter and George Brown. These instruments are often referred to as interviewer-based semi-structured interviews. While largely structured, the interviews permit a specially trained interviewer to make judgments about the material being provided by the subject as the interview progresses. Thus, the coding and data gathering phases are in a sense overlapping. These instruments have achieved high levels of reliability, and the track record of the research groups that have used these instruments shows that they can lead to significant advances in connecting environmental influences and psychopathology (Bifulco, Brown & Adler, 1991; Brown, Bifulco & Harris, 1987; Leff & Vaugh, 1989). A detailed description of the measures is presented below.

4.2.2 A description of the adult outcome measures

a. Psychopathology, personality disorders and the use of mental and physical health services in adulthood

Psychiatric disorder and the use of mental health services during adulthood are assessed using the SADS-L, the SCID-II, the SWAP-200 and the SF-36. These instruments provide information regarding the long-term outcome of childhood diagnoses, in terms of both psychiatric disturbances and personality disorders. In addition, information regarding the use of mental and physical health services in adulthood sheds important light on the subjects' quality of life as well as on the cost-effectiveness of psychoanalytic treatment in childhood.

The Schedule for Affective Disorders and Schizophrenia (SADS-L)

The SADS-L (see Appendix 4.1) was developed by Endicott and Spitzer (1978) for the assessment of psychopathology and the differential diagnosis of affective disorders and schizophrenia. It is a semi-structured interview that focuses on past and current psychiatric history and treatment and is generally used with non-patients (Rubinson & Anis, 1989). Several studies have reported strong validity (see Rubinson and Anis, 1989) and inter-rater reliability (Endicott & Spitzer, 1978, in Rubinson & Anis, 1989), as well as test re-test reliability (Williams, Gibbon, First, Spitzer, Davies et al., 1992).

The SADS-L begins with a demographic section, followed by an overview of past and current physical illness and treatment, as well as psychiatric treatment. Assessment focuses then on smoking and alcohol dependence and on the following disorders: generalized anxiety, panic disorder, phobic disorder, obsessional-compulsive disorder, depression, suicidal behavior, manic symptoms, bipolar disorder, cyclothymia, derealization and depersonalization, delusions, psychotic symptomatology, drug abuse and dependence, eating disorders, and adjustment disorder. Ratings are made based on screening questions and requests for specific examples. Symptoms are assessed in relation to severity, intensity, and frequency of symptoms. The coding of presence and severity of symptoms is as follows: 0 (not present); 1 (doubtfully present at all); 2 (present and of moderate intensity); 3 (present and severe); 8 = not applicable; 9 = not known. For the current study, the author expanded the SADS-L to include screening questions and ratings for post-traumatic stress disorder. Two clinical and research psychiatrists reviewed the screening questions and ratings scales for this additional diagnosis in order to confirm its validity and reliability.

The Structured Clinical Interview for DSM-III-R (SCID-II)

The SCID-II (see Appendix 4.2) was developed as a self-report structured interview for the assessment of personality disorders, based on DSM-III-R criteria (First, Spitzer, Gibbon & Williams, 1985; Spitzer, Williams, Gibbon and First, 1990). It covers 12 personality disorders: Avoidant, Dependent, Obsessive-Compulsive, Passive- Aggressive, Paranoid, Schizotypal, Schizoid, Histrionic, Narcissistic, Borderline, Antisocial, and Self-Defeating, as well as a residual category for the assessment of 'personality disorder not otherwise specified'. It is comprised of 130 yes/no direct questions regarding usual behavior, moods, relationships with others and cognitions. The interviewer follows up questions with probes regarding specific examples. The ratings are based on the interviewer's clinical judgment and the coding is as follows: 1 = "absent or false", 2 = "sub-threshold", 3="threshold or true". Although this interview relies on direct questions, the ratings require a certain degree of clinical judgment and, for this reason raters must have clinical experience and extensive training in the measure (Dressen & Arntz, 1998). Various studies have found the SCID-II to be both reliable and valid (e.g., Ekselius et al., 1994; First et al., 1995). Diagnoses obtained by the SCID-II were also found to be

comparable to those obtained by other widely used structured clinical interviews (O'Boyle and Self, 1990; Oldham et al., 1992; Skodol et al., 1991).

The Shedler-Westen Assessment Procedure (SWAP-200)

The SWAP-200 (see Appendix 4.3) offers an alternative to the SCID-II for the assessment of personality in an attempt to avoid many of the pitfalls of the DSM Axis II diagnostic system (see Blatt & Levy, 1998; Deary, Peter, Austin & Gibson, 1998; Nathan, 1998). According to its authors, the SWAP-200 serves both clinical and research needs by capturing the richness and complexity of clinical personality descriptions while at the same time providing reliable and quantifiable data (Shedler and Westen, in press; Westen & Shedler, 1999a, 1999b). It enables clinically meaningful narrative descriptions of the patient's most salient features and, at the same time, lends itself to statistical analysis. Ratings are made on the basis of a semi-structured clinical interview that resembles a psychotherapy session.

The SWAP is comprised of 200 personality-descriptive statements or items. A Q-sort method is used in which the rater sorts the items into eight categories, ranging from those that are least descriptive of the patient (assigned a value of 0) to those that are most descriptive (assigned a value of 7), in keeping with a fixed distribution (Westen & Shelder, 1999a, 1999b). The items include descriptions of personality based on patterns of thought, behavior, affect, interpersonal relationships, motivation and functioning. They cover criteria from the DSM personality disorder classifications, as well as Axis I criteria that are relevant to personality (e.g., anxiety and depression). In addition, the items include personality constructs described in clinical and research literature and were drawn from the clinical observations of hundreds of experienced therapists who participated in multiple pilot studies conducted by the authors.

The SWAP-200 can be used to generate empirically derived prototypes for the DSM-IV Axis II personality disorders (PD Scores). In addition, it generates new personality categories (Q-factors), labeled as: Dysphoric (subdivided into avoidant, high functioning neurotics, emotionally disregulated, dependent-masochistic, and hostile-externalizing), Antisocial-Psychopathic, Schizoid, Paranoid, Obsessional, Histrionic, and Narcissistic. The SWAP-200 requires the assessment of two raters and has demonstrated both good

reliability (Shedler & Westen, 1998) and validity (e.g., Shedler & Westen, in press; Westen & Chang, 2000; Westen & Shedler, 1999a, 1999b).

Mental and physical health

Physical health, illness and treatment are assessed in the first part of the SADS-L. This information is supplemented by the SF-36 Health Survey (Ware et al., 1993), a brief self-administered measure of generic health concepts. The SF-36 (see Appendix 4.4) covers eight health scales (Physical Functioning, Role Functioning-Physical, Bodily Pain, General Health, Vitality, Social Functioning, Role Functioning - Emotional, Mental Health and Reported Health Transition) that yield a standardized health profile. In addition, the use of mental health services in adulthood is assessed by the SADS-L in which first, latest and most severe psychiatric episodes are investigated, including detailed information on consultations and treatments.

b. The assessment of adult functioning

In keeping with the goals of the follow-up study, several measures that assess different aspects of personality functioning were included in the protocol. These include measures that examine the quality of functioning across various domains (the APFA), the ability to plan for and negotiate transitions at successive stages in adult life (the TAPI), and the ability to cope with stressors and adversity (the IOS).

The Adult Personality Functioning Assessment (APFA)

The APFA (see Appendices 4.5 and 4.12) is an investigator-based standardized interview that assesses patterns of specific and general social dysfunction (Hill et al., 1989). It is based on the assumption that pervasive interpersonal dysfunction is a central aspect of personality disorders, but that levels of functioning can vary from one domain to another. It covers adult functioning across two time periods, current (last five years) and baseline (ages 21-30) in the areas of work, love relationships, friendships, other social contacts, negotiations and everyday coping. The two time periods enable a comparison between past and current social functioning, and between pervasive and situational dysfunction. Each domain is rated from 1 (remarkably good functioning) to 6 (picture dominated by discord, disagreement, disorganization, conflict). The APFA takes into account that

impaired social functioning can be due to adverse circumstances in life and/or to physical or psychiatric illness. As such it helps to facilitate the distinction between Axis I and Axis II disorders. The authors report good inter-rater reliability (Hill et al., 1989, 1995) and construct validity (Mufson, Aidala & Warner, 1994) for the APFA.

The Transitions and Plans Interview (TAPI)

The TAPI (see Appendices 4.6 and 4.12) examines the ways in which individuals plan for major transitions. Plans are defined as a cognitive representation of intention that expresses itself in a course of action aimed at a specific goal. According to the author of the TAPI (Champion, 1986), planning should be seen as a very complex process that is neither good nor bad in itself. Rather, the extremes of planning are problematic, such as failure to plan on the one hand, or rigid planning, on the other hand. In order to assess planning, a semi-structured interview is used to ask subjects about the ideas they had when they finished or left school regarding the areas of work, relationships, and independent living. They are then asked to talk about their plans, setbacks and adjustment and how these compared with their hopes and expectations. Ratings for each domain are given on a scale of 1 to 8 (1 = definitely planned, 2 = possibly planned, 3 = passive planning, 4 = planning unclear, 5 = definitely not planned, 8 = not applicable).

The Impact of Stress or Coping Interview (IOS)

At the time that the follow-up study was being developed, a review of coping measures revealed a lack of suitable instruments for the current study. Many existing measures tended to suffer from psychometric limitations (see review by Endler & Parkers, 1990; Vitaliano et al., 1985), were of a self-report nature, or often related to hypothetical stressors. In addition, most existing measures presupposed that individuals employ a consistent coping style across a wide range of situations. However, studies show that there tends to be little consistency in coping styles across different life situations (Pearlin & Schooler, 1978; Folkman & Lazarus, 1980). As a result, the current author created the Impact of Stress Interview (IOS), based on existing coping measures, which focuses on problem-solving behaviors, cognitive responses to stressors, and psychosomatic reactions to adversity. Specifically, cognitive responses to stressors highlighted in the Bifulco and Brown (1996) coping measure were incorporated into the IOS interview. So, too, psychosomatic reactions to adversity explored by the Westen and Shedler (1999a,

1999b) Personality Diagnostic Interview were integrated into the IOS measure. In this way, the IOS aimed to capture the richness and complexity of coping styles across multiple domains.

The IOS (see Appendix 4.7) is a semi-structured interview in which subjects are asked to describe a particularly stressful event or situation that occurred during the last five years in each of the following domains: Work/Study, Intimate Relations, Friendships, Family (parenthood or family of origin), or Other, if no example can be found for one of the previous four domains. Since the goal of the interview is to assess coping strategies for particularly difficult events (similar to the LEDS definition of a severe event of 1 or 2 rating, see below), interviewers are free to bring up examples discussed in other parts of the interview in the event that the subject brings up a less stressful event. The subject is then asked a series of probes for each stressful event, including a description of what happened, how they handled it, how they coped, whether they experienced somatic symptoms in response to the stress, whether others became involved to help sort out the problem, etc.

In order to rate the subjects' coping strategy, three primary dimensions are taken into account. One relates to the complexity of the strategy. In other words, one needs to assess how elaborate or sophisticated the described coping strategy is (i.e., does the subject evaluate the cause of stress in some depth; does s/he give sufficient weight to his or her own contribution as well as to the contribution of others to the difficulty?). The second dimension relates to the appropriateness of the coping strategy. For instance, did the subject act in a timely manner? Is the strategy suited to the situation? Is it likely that the strategy will have a desirable impact on the stress (regardless of actual outcome), or is it likely to make it worse? Appropriateness is anchored in terms of potential rather than actual outcome. The final dimension relates to the activity or passivity of the subject in response to the stressful situation. In other words, to what extent does the subject deny or ignore the stressful situation; does the subject face the situation and choose a course of action or does the subject act impulsively? Coping scores are assigned for each individual domain on a scale of 1 to 4 (excellent to very poor). In addition, an overall coping score is assigned to each subject. This overall score was designed by the author to reflect the subject's ability to cope flexibly and specifically

versus rigidly and globally across domains and is not, necessarily, a numerical average of the four individual coping domains. Thus, for example, if a subject continually uses the same strategy regardless of the situation or domain, s/he would receive a lower overall score than a subject who displays the use of varying strategies for different domains and situations.

In order to test the reliability of the measure, the research staff of the Anna Freud Centre trained a research member of the Menninger Foundation (Darla Allen) in the administration and scoring of the IOS. Initial reliability ratings for 15 subjects yielded a Pearson correlation coefficient of .60. Discrepancies in ratings usually related to the 2-3 cut-off point, in which raters from the follow-up research team tended to give the higher of the two ratings. In response to this discrepancy, the raters conferenced the coping scores of five subjects whose ratings differed on this cut-off point and two additional subjects who had a different one-point discrepancy. Conferencing helped to clarify this functional/dysfunctional distinction leading to an improved reliability of .72 for the full sample (n=15).

c. Adult attachment status and reflective functioning

In keeping with the goal of the follow-up study to examine individuals' internal attachment representations and psychological resilience, the protocol includes an assessment of subjects' adult attachment status and their capacity for reflective functioning. Ratings for both measures are based on the transcribed Adult Attachment Interview described below.

The Adult Attachment Interview (AAI)

The AAI (see Appendix 4.8) is a structured semi-clinical interview designed by George, Kaplan and Main (1985) for the assessment of internal working models of adult attachment. In order to explore early attachment experiences and their effects, the subject is asked to describe his or her early relationship with his or her family of origin, to choose five adjectives that reflect his or her childhood relationship to his or her main caregivers, and to talk about possible experiences of separation, rejection, abuse and loss of significant others in childhood. Subjects are asked to describe specific memories and

are invited to think about the possible impact of early experiences on his or her development and adult personality. So, too, they are asked to speculate on the reasons for their parents' behavior toward them. The last part of the interview focuses on the subject's relationship with his or her own children.

The AAI is audio-recorded and transcribed verbatim with detailed attention given to pauses, incomplete sentences and words, and special errors. The transcript is rated by a trained and certified rater, focusing on the relationship between the information consciously provided by the subject and unconscious aspects reflected in language and discourse style, according to a detailed manual (see Main and Goldwyn, 1994). The AAI classification system includes five categories: Secure/Autonomous/Free (F), Insecure/Dismissing of Attachment (Ds), Insecure/Preoccupied/Entangled (E), Unresolved/Disorganized with regard to loss or abuse (U), and 'Cannot be Classified' (CC). This system parallels the child attachment classification system based on Ainsworth's (Ainsworth, Blehar, Waters & Wall, 1978) Strange Situation Procedure (securely attached, insecure/avoidant, insecure/ambivalent/resistant, and disorganized/disoriented). The interview has been administered extensively in many countries, with high reliability and both strong construct and discriminant validity (Bakermans-Kranenburg & van IJzendoon, 1993; Benoit & Parker, 1994; Sagi, van IJzendoorn, Scharf, Koren-Karie, Joels & Mayseless, 1994).

Reflective Functioning Scale (RF)

As mentioned, the RF scale (see Appendix 4.9) is rated on the basis of the AAI transcripts (Fonagy et al, 1996; Fonagy et al., 1998). It assesses interviewees' capacity to understand mental states and their readiness to contemplate them in a coherent manner (Fonagy et al., 1996). RF ratings are based on the frequency and complexity of the reflective stance in relation to the self and others and are given on a scale of -1 (minus 1) to 9. Nine indicates full or exceptional RF levels, 7 reflects marked reflective functioning, 5 represents ordinary levels, 3 reflects low or questionable levels, 1 reflects the absence of reflective functioning, and -1 indicates negative or repudiated reflectiveness. Scores are given to specific responses to AAI questions (demand questions) and also to additional, spontaneous responses (permit questions). Fonagy and colleagues (1996) have reported excellent inter-rater reliability on the RF scale. Good

discriminant validity with other attachment measures has also been reported (International Psychoanalytic Association, 2001).

d. Measures of stress and adversity

In light of the relationship between severe life events and the onset of psychiatric illness (Brown & Harris, 1978, 1986), as well as the strong association between emotional and behavioral disturbances in childhood and severe life events in adulthood (Champion et al., 1995), it was important to include an assessment of adversity and stressors across the adult life span.

Life Events and Difficulties Schedule (LEDS)

The original LEDS (see Appendix 4.10) is a semi-structured investigator-based interview that covers key events in adult life across a wide range of domains including: education, work, reproduction, housing, money/possessions, crime/legal, health (treatment, accidents, substance misuse), marital/partner relationship, other relationships and miscellaneous. Severity ratings for events and difficulties are made by the interviewer/rater on a scale of 1 to 4 (most to least severe) based on contextual information. For purposes of the follow-up study, the current author worked together with the LEDS authors to create a briefer 'mini-LEDS' protocol. In addition, the period examined by the mini-LEDS was expanded from one to five years preceding the interview, in keeping with the Champion and colleagues' study (1995).

The Adult Life Phases Interview (ALPHI)

The ALPHI (see Appendices 4.11 and 4.12), developed by the Medical Research Council in London (Bifulco, Bernazzani, Moran & Ball, 2000), assesses retrospectively key adult experiences across the life span. In particular, it focuses on negative characteristics of the social and material environment that have been shown to increase the risk of clinical depression or anxiety. The interviewer divides each subject's adult life starting from age 17 into various life phases, taking into account the changes occurring in an individual's routine, roles and living group at different times in his or her life. Subjects are then asked about different types of adversity in several domains for each life phase. The primary domains include partner/sexual domain, parenthood and social domain (including close friends and family of origin), material domain (including work, housing

and financial areas), and 'miscellaneous' covering physical health, and legal and geopolitical events. The interviewer objectively assesses the level of adversity in each domain in terms of the average person's likely emotional response to such an experience rather than the subject's actual response. Severity ratings are made on a scale of 1 to 4 (severe to little or no adversity). In addition to mapping out and rating adversity for the four domains in each life phase, the ALPHI includes a rating sheet that records possible support or lack thereof within the marriage or cohabiting relationship. A partner record is completed for each long-term partner (minimum six months cohabiting) and includes various demographic data as well an assessment of the overall quality of the relationship over time. The ALPHI has been extensively validated in a large epidemiological study of women at risk for depression in a deprived area of London (Bifulco et al., 2000).

4.2.3 Training in the administration and rating of the outcome measures

Following the selection of measures for use in the follow-up study's interview protocol, the current author received extensive training in the administration and rating of the all of the measures described above. With the exception of the SADS-L, SCID-II and SF-36, the author was trained by the original authors of the measures. During the course of the study, ten clinical research assistants participated in the study as raters and/or interviewers. The author trained the researchers in the administration and rating of the majority of the measures. All interviewers were required to conduct several recorded practice interviews and the author provided feedback to them in order to improve fluency and accuracy. Regarding the reliability of the interviewers' ratings, the authors of each measure determined the necessary requirements. For some of the measures, such as the LEDS, ALPHI and APFA, interviewers were required to present several interviews and ratings to the authors of the instruments at regular consensus meetings. In the case of the AAI, passing an official rating exam (in which 30 consecutive AAI transcripts are rated) is required to become an approved AAI rater. The author received approval to interview and rate all of the interview measures, including the AAI, enabling her to interview subjects and rate all types of interview data.

4.2.4 Consolidation of the interview protocol

In the initial stage of the study, researchers conducted the first 13 pilot interviews using the interviews in their original form. However, it became readily apparent that there was a high degree of overlap between the measures leading to an extremely lengthy and repetitive protocol. As a result, the author combined and streamlined the measures into a single cohesive interview protocol (see Appendix 4.12 for instructions to and final version of the protocol). This resulted in a briefer, less repetitive and more integrated protocol. Before commencing the next phase of the study, the author presented the new interview protocol to the authors of the original measures during several consensus meetings, to ensure that the abridged version of the interviews did not alter the quality of the elicited data, enabled accurate ratings, and maintained the measures' original validity and reliability. Once approved by the authors, the revised interview protocol was administered to the remaining 21 subjects by the author and other members of the follow-up study research team.

The primary areas of overlap between the measures related to demographic questions and to particular domains in adult life that are covered by several of the interviews (i.e., work/study, intimate relationships, friendships, etc.). For example, several measures begin with a demographic section (i.e., the SADS-L, ALPHI, TAPI, etc.). Rather than repeat these questions, the various demographic sections were combined into one extended demographic protocol (see Appendix 4.13). In addition, two of the adult measures that include similar questions regarding parallel domains, the ALPHI and the APFA, were merged into one interview schedule from which multiple ratings are made. Familiarity with the interview schedules' original format and their rating criteria and procedures was essential for all of the interviewers in order to elicit the necessary information for both measures. So, for example, the interviewer had to keep in mind the different time bands used in the ALPHI as opposed to the APFA interview (in the former, adult life is divided into phases, starting at age seventeen whereas in the APFA the relevant time bands are age 21-30 and the last five years). In addition, the two protocols have different foci: The ALHPI focuses on adversity and subsequent coping whereas the APFA looks in detail at functioning in several different domains. The merged protocol is thus comprised of a number of different domains. Most are relevant to both ALPHI and APFA measures, but some are relevant to only one. Similarly, the SWAP measure,

which in its original form is based on a lengthy clinical interview, was incorporated into the abridged protocol. Vignettes related to relationships with partners, family members and work colleagues were elicited at relevant times in the merged ALPHI/APFA interview. So too, questions regarding childhood that are covered by the AAI were not re-asked, and questions regarding physical reactions to stress were covered in the IOS interview. Finally, a set of questions regarding the subject's sense of their own identity, future plans and fears were asked at the end of the ALPHI/APFA protocol. Eliminating most of the redundancies across the measures resulted in a more manageable and 'interviewee friendly' protocol and significantly decreased interviewing time.

4.3 THE FOLLOW-UP STUDY PARTICIPANTS

4.3.1 Research design and selection of study participants

At the onset of the follow-up study project, Prof. Peter Fonagy and Dr. Mary Target of the AFC and University College London discussed the study's design with Prof. Michael Rutter of the Institute of Psychiatry, and with other experts in the field including Dr. David Quinton (University of Bristol), Tirril Harris (Royal Holloway and Bedford College, University of London), and Dr. Lorna Champion (University of Edinburgh and Royal Edinburgh Hospital). In its initial conception, the follow-study was designed to enable comparisons between four groups of subjects. First, the study aimed to compare subjects who had received intensive psychoanalytic treatment in childhood (4-5 sessions per week) with those who had received non-intensive treatment (1-3 sessions per week). This comparison was deemed important given the results of the AFC retrospective study of psychoanalysis described in section 3.3 which found that high frequency of treatment led to greater improvement independent of the child's age or length of treatment and was significantly helpful for children suffering from comorbid disorders and severe disturbance. Unfortunately, this comparison had to be abandoned as the tracing and contacting of treated subjects turned out to be more difficult than originally anticipated. Of the 34 treated subjects who eventually participated in the study, the overwhelming majority (26 out of 34) had received intensive psychoanalytic treatment in childhood, rendering a comparison between the two treatment groups untenable.

In addition, the follow-up study aimed to compare the long-term outcome of both groups of treated subjects with an appropriate, untreated control group. As described in section 3.2.c, creating a non-treated control group poses multiple ethical and practical difficulties for outcome research. These difficulties are all the more challenging in a retrospective research design. Initially, the follow-up study conceived of two control groups. The first was comprised of siblings of treated subjects who had not received treatment at the AFC in childhood. Siblings were chosen as an appropriate comparison because their psychosocial circumstances are most likely to be similar to those of the treated subjects (see Sawyer, Toogood, Rice, Haskell, & Baghurst, 1989 and Robins, Schoenberg, Holmes, Ratcliff, Benham & Works, 1985 for similar design). Despite the notion of non-shared environments (Plonim & Daniels, 1987), siblings were perceived as providing the closest match to family background. Initially, siblings within 3 years of age of treated subjects were selected. However, due to the tracing difficulties described in section 4.3.3, selection criteria were relaxed to include siblings within a six year age range of the treated subjects. In the end, sixteen siblings participated in the follow-up interviews. However, for one-third of the siblings the data from key outcome measures was missing (see section 4.3.3 for an explanation of the loss of data). As a result, the sibling group was not large enough to use as a control group. Individual case comparisons of pairs of treated subjects and their siblings are presented by Fonagy and colleagues (1999).

The second control group was designed to include subjects who had been referred for treatment due to childhood disorders but who had remained untreated. Subjects were to be drawn from the AFC case files and from the records of local child mental health services, including those who matched the treated subjects on demographic and broad clinical variables. Unfortunately, both control groups turned out to be unviable. Ten subjects who had been referred for treatment to the AFC but who had not received it participated in the follow-up study. For half of them, a significant proportion of data was missing (interviews were not completed, subjects withdrew from the study before completing the interviews, poor audio recordings, etc.). In addition, several of the subjects had received alternative forms of treatment in childhood or adolescence, and case files were often sparse and uneven in detail in comparison to the files of treated subjects. As for the second source of disordered but untreated subjects, access to the

files of local clinics turned out to be extremely problematic, particularly due to ethical considerations.

As a result of these formidable obstacles, the author focused the analysis of the follow-up data on the long-term outcome of treated subjects only. This focus enables an in-depth look at the long-term outcome of childhood psychopathology as well as the long-term outcome of treatment intervention in childhood on the adult functioning of 34 individuals. It also allows for a preliminary look at possible moderators of adult outcome. Although the lack of a control group clearly limits the ability to draw firm conclusions or to make broad generalizations based on the study's findings, the treated subjects who participated fully in the study form a unique, naturalistic-based sample, whose life histories can shed important light on many of the questions facing outcome research, helping to refine the research design and focus of future outcome studies.

4.3.2 Inclusion/exclusion criteria

At the onset, it was determined that treated subjects included in the follow-up study be between the ages of 25 and 45 to ensure a roughly comparable stage of life. Due to the difficulty in reaching large numbers of treated subjects, the age range was increased to 50, thereby creating a group of subjects in early to mid-adulthood. In addition to the age criterion, subjects with a history of mental retardation, autism or psychotic illnesses were excluded from the study as these syndromes are known to have poor long-term outcomes and are not expected to benefit significantly from childhood psychoanalysis. Based on these criteria, two research assistants reviewed the 763 files included in the AFC retrospective study (see section 3.3.) and selected those individuals who met the above criteria. This process took place at the same time that the interview protocol was being compiled (see section 4.2).

4.3.3 Tracing potential subjects

Before searching for the current addresses of individuals meeting the inclusion/exclusion criteria of the study, the author received ethical committee approval for the tracing of previous AFC patients. The bulk of the tracing was carried out by the tracing staff of Dr. Barbara Maughan, of the Institute of Psychiatry, who generously volunteered to include our potential subjects in the tracing lists of their own separate follow-up study. In addition, current addresses were sought through the assistance of the National Register, telephone information services, and the like. Of the roughly 400 former patients who met criteria for inclusion in the study, nearly 50% could not be traced, even using all available means. Of the approximately 200 traced subjects for whom we had obtained addresses, 1.5% had died, 17% did not respond to repeated letters (the traced address may have been incorrect and were retraced several times during the course of the study), 16% declined to participate, and 3.5% agreed to complete questionnaires but were not available for interview (these subjects generally lived outside the UK). The remaining 14% agreed to be interviewed. Thus, of those whose whereabouts we succeeded in establishing, 42% agreed to full interviews, and a further 10% agreed to complete extensive questionnaire measures. Of the approximately 60 subjects who agreed to be interviewed, in the end 34 subjects actually participated in the study. This sizable attrition rate was due to a significant time lag (often years) between initial postal contact and the actual time when subjects were telephoned in order to set up interview dates. As a result of this time lag, ten subjects had changed address and could not be reached at the contact details they initially provided, nor did tracing turn up new addresses for them. In addition, five subjects had taken up new full-time employment and no longer felt they could afford the time commitment required for the interviews. An additional four were no longer willing to participate due to changes in personal circumstances, such as pregnancy, recent births and parenting demands. Finally, material from seven subjects who had begun the interviews was lost when one of the study's interviewers very unfortunately disappeared and exhaustive efforts to trace her failed. It was felt inappropriate to contact those subjects and ask that they repeat the extensive interviewing they had already undergone, despite the significant loss to the study.

The inevitable reduction in sample size between the total group of subjects we attempted to trace and those who ultimately participated in the study was rather large. The high

attrition rate naturally raises questions regarding the degree to which those individuals who did participate were representative of the total sample. It is possible that those subjects who agreed to participate represent the better functioning portion of the sample, the so-called 'satisfied customers'. Alternatively, they may represent the more disturbed segment of the sample, those individuals with a poorer outcome who are still in need of help. Although it is clearly impossible to compare the adult outcome of those who participated with those who could not be traced or refused to participate, it was possible to compare data from their case files. This comparison did not yield any significant differences on childhood variables. A comparison of the 34 subjects who comprise the follow-up sample with the 763 cases whose files were analyzed in the retrospective study will be presented in section 4.5.

4.4 THE INTERVIEW PROCESS

Parallel to the training process, the author oversaw the administration of the study, keeping track of the results of the tracing procedure, sending out letters to the adult subjects who had been treated at the AFC in their childhood, and who met the inclusion criteria of the study, and assigning interviewers to the various subjects who consented to participate in the study. The letters sent to potential subjects included a description of the study and a request to participate in the study. Those who responded affirmatively were then contacted by telephone to set up interviews. These took place either at the AFC or at the subjects' homes, according to their preference. Interviews were divided into two sections. The first part focused on childhood measures, taking one session to complete. The second part, focusing on adult outcome measures, was lengthier and required between three and four sessions. Sessions usually ranged between three and four hours, and the entire battery of measures took between 10 and 16 hours on average to administer. All interviews were audio-recorded. Table 4.1 presents the interview protocol, including information on the style, content, and time required to administer each interview. In order to minimize the potential effect of knowledge regarding childhood on rating adult outcome, two different interviewers administered and rated the interview protocol for each subject, one for childhood and one for adulthood. During the pilot phase of the study, in which the first 13 subjects were interviewed, three clinical

interviewers (including the author) conducted the follow-up interviews and rated the interview material, with the exception of the AAI which was rated by the author or other approved AAI raters. For all other measures, ratings were discussed and reviewed among the three interviewers after all of the interviews had been completed.

4.4.1 The first interview

At the onset of the first interview, the interviewer began by engaging the subject in light conversation and offered some refreshments in order to put the subject at ease. Once an initial rapport was established, the interviewer requested that the subject sign the follow-up study consent form (see Appendix 4.14) and described to the interviewee what was planned for the first meeting. To begin, subjects were asked a series of demographic questions whose answers were written down by the interviewer on a demographic sheet designed for this purpose (see Appendix 4.13). Demographic information included the subject's date of birth, age, current work status (type of work, number of hours, etc., in order to determine socio-economic status), marital status (with or without long-term cohabiting partner), number of children, presence of close others (relatives or friends) and degree of contact with them. Next, the subjects were administered a brief verbal intelligence test, the National Adult Reading Test (NART, see Appendix 4.15), which enables the rater to assess a verbal intelligence score and to estimate performance and overall IQ scores. Since subjects may feel uncomfortable being asked to read aloud a list of words, some of which may be unfamiliar to them, the interviewer commented on the fact that most individuals are unfamiliar with all of the words, but that for the purpose of the study, the subject is required to attempt to read them all aloud. The NART was then followed by the AAI. In keeping with the AAI manual instructions, the interviewer is not allowed to say anything other than the introductory guidelines written in the AAI protocol so as not to take away the element of surprise aroused by the questions (see Appendix 4.8). At the end of the session, the interviewer explained that the remainder of the study's interviews would be conducted by a second interviewer who would be unaware of the subject's childhood background and who would focus solely on the subject's adult life. After completion of the first set of interviews, the second interviewer contacted the subject to set up a date to continue the interviews.

4.4.2 The second interview

The second interviewer began the session by establishing a rapport with the subject, possibly commenting on the difficulty in getting used to a new interviewer. Since this session is devoted to the psychiatric measures (SADS-L and SCID-II), the interviewer commented on the different style of these interviews as compared to the ones carried out in the first meeting. These measures are more directive and less open-ended than the AAI. In the event that the interviewee had not experienced many of the disorders or behaviors asked about in the interviews, the interviewer would point out that some of the questions may feel alien to the subject but that, for research purposes, it was necessary that everyone be asked the full set of screening questions. At the conclusion of the second session a date was agreed upon for the following meeting.

4.4.3 The third interview

The third session commenced with the TAPI followed by a set of questions regarding the period when the subject first left home permanently (see Launching Questions, Appendix 4.16), as this sets the backdrop to the ALPHI. Before commencing the ALPHI, the interviewer needed to establish the precise number and approximate dates or ages of the subject's adult life phases. At this point, the recording was often halted while the interviewer consulted with the subject on his or her life phases. Interviewers used a pencil and paper to write down the specific phases and their corresponding ages. This timeline served to keep the interview on track and could later be used for dating severe life events in the LEDS interview. As mentioned earlier, in order to minimize repetition the ALPHI protocol was merged with the APFA as well as with sections of the SWAP-200 personality interview. As a result, this part of the protocol was the most complicated for the interviewer to conduct as s/he had to simultaneously keep in mind the ALPHI life phases, and the two APFA time frames - baseline (age 21-30) and current (last five years), as well as their different foci. So, too, at the relevant sections, the subject was asked to describe two vignettes that demonstrated something that was characteristic of his or her relationship to partner, sibling, child and working life. Because of the need to juggle multiple variables and rating guidelines, the interviewer was encouraged to jot done reminders or notes on the timeline described above. Often, the integrated protocol

could not be completed in one session and the remainder was carried out in the final session.

4.4.4 The final interview

In the event that the material described in the third session was not completed, the interviewer continued from where s/he had left off. This was then followed by the LEDS interview and the IOS. For LEDS ratings, subjects were asked to remember as precisely as possible the exact dates on which the stressful events they described took place. For this purpose, the above mentioned timeline was used to clarify and help jog the interviewee's memory. Since both the LEDS and IOS measures focus on adversity, interviewers were encouraged to try to conclude the interview on a more positive note, possibly by asking the subject to discuss an event mentioned earlier in the interview process that had a positive ending or regarding which the subject demonstrated positive coping and inner resources. Subjects were asked how they felt about the entire interview process and were thanked sincerely for sharing generously of their time, memories and emotions. Given the potential of the interviews to arouse strong memories and feelings in the subjects, interviewers were offered the opportunity to talk to a senior member of the research team (Dr. Mary Target), an experienced clinician trained professionally to help in these situations. Participants were told that Dr. Target could refer them to a therapist or counseling service should they wish to do so. Finally, permission was asked to contact the subject by telephone in the event that during the rating process the rater required additional information that had been overlooked in the interview.

Table 4.1. Interview protocol: style, domains and average length (in minutes)

Interview	Interview Style	Domains and Ratings	Length
DEMOGRPAHICS	Structured	Date of birth, work, marital and parental status, confidants	10
NART	Structured	Verbal intelligence and estimated performance and overall IQ scores	5
AAI	Structured semi-clinical	Attachment relationships with primary caretakers in childhood; yields 5 attachment classifications	45-90
RF	Based on AAI transcript	Understanding and contemplation of mental states rated from -1 to 9	0
SADS-L	Semi-structured	Physical and mental health, use of services, past and current psychiatric diagnoses	45-60
SCID-II	Structured self-report	11 personality disorders diagnoses based on usual behavior, moods, relationships and cognitions	60-90
SF-36	Self-report questionnaire	Recent physical and mental health yielding an 8-scale health profile	15
TAPI	Semi-structured	Plans and transitions scores for education/work, relationships and independent living and overall planning score rated from 1 to 8	60
LAUNCHING	Structured	Leaving home, first significant intimate relationships, pregnancies	15
ALPHI*	Semi-structured	Adversity ratings of 1 to 4 in partner, family/social, material and other domains for each adult life phase	60
APFA*	Investigator-based standardized interview	Baseline and current ratings (1 to 6) for work, love relationships, friendships, social contacts, negotiations, coping, and overall functioning score	
SWAP-200*	Semi-structured clinical interview	Q-sort of 200 items yields DSM-IV personality disorders (PD scores), new personality categories (Q scores), and narrative description of subject's salient characteristics	60-90
LEDS	Investigator-based, semi-structured	Key stressful life events in last 5 years rated from 1 to 4 based on contextual severity	45-60
IOS	Semi-structured	Coping strategies for work/study, intimate relationships, friendships and family rated on scale of 1 to 4, and overall coping score.	60

*These interviews were merged (see section 4.2.4) and together took approximately 90-120 minutes to administer

4.5 THE SUBJECTS' CHILDHOOD BACKGROUND

Before moving on to the results of the follow-up study, the childhood background of the 34 subjects who participated in the study is presented. This information is based on their childhood case files which formed the basis of the AFC retrospective study described in section 3.3. The files provide a rich and fairly systematic source of information regarding the childhood background of the adults participating in the follow-up study. Target (1993) presented an historical description of the AFC along with a detailed description of the type of data elicited from the childhood files. The retrospective chart review incorporated information regarding the AFC's patients including a social history of the child's family, a psychological evaluation of the child by a clinical psychologist, diagnostic interviews with the child at referral including a discussion of the child's underlying pathology and suitability for treatment, school reports, a provisional diagnostic profile, weekly progress reports, summaries of interviews with parents, formal reports describing the child's difficulties, treatment and outcome, a termination profile or closing summary, and information on follow-up interviews or correspondence with the child or parents. Not all of this information was present in all cases, highlighting one of the difficulties with retrospective investigations. However, for most cases, a very rich and multi-focal source of information was available. A summary of the childhood variables relevant to the subjects participating in the follow-up study appears below. They include Demographic and Family Variables, Parental Psychiatric Status, Child and Clinical Variables, Treatment Variables, and Termination Variables. Throughout the presentation, attention is given to the ways in which the follow-up study sample compares to the larger retrospective study sample from which they were drawn. Chi-square and non-parametric trend analyses comparing the distribution of the above variables within the two samples are presented, highlighting those variables for which significant differences are found. Unfortunately, due to the follow-up study's small sample size and subsequent small cell sizes, the expected frequencies of many of the chi-square analyses necessitate a cautious interpretation of their findings.

4.5.1 Demographics and family variables:

a. Family structure

The majority of subjects in both the follow-up and retrospective samples was raised by both their biological parents (82% and 71.3% retrospectively) and a significantly smaller percentage was raised by a single parent (3 follow-up subjects and 112 or 14.7% of the retrospective sample). In both groups, a small percentage of subjects were raised by adoptive parents (3 follow-up and 22 retrospective sample subjects). Although none of the follow-up subjects were raised in reconstituted homes, children's homes, foster care or long-term hospitalized care (about 11% or 85 subjects from the full sample), a chi-square analysis did not reveal significant differences between the follow-up and retrospective samples regarding this variable (see Appendix 4.17).

b. Socio-economic status (SES) and parental employment

Within the follow-up sample, the overwhelming majority of patients' fathers were employed at the time of referral with only one case of unemployment. Socio-economic status was assigned on the basis of the father's type of employment and professional training (except in the case where father was unemployed and data was based on mother's professional training and employment). Follow-up families were assigned to one of five socio-economic groups based on the Registrar General's Classification (RGC) system (Office of Population Censuses and Surveys, 1980). A Kendal's trend test did not reveal significant differences between the socio-economic status of the follow-up sample as compared to the full retrospective sample. In both groups, the majority of families were assigned to the two highest socio-economic groupings (64.2% of the full sample and 81.9% of the follow-up sample). A detailed breakdown of the two samples' socio-economic groupings can be found in Appendix 4.18.

c. Ethnic and religious background

The majority of the follow-up sample's parents were born in the UK or Ireland (25 of the fathers and 20 of the mothers). For those families in which religious affiliation was recorded (21), the majority were Jewish (16 fathers and 15 mothers), and the remaining

were affiliated as Church of England (2 fathers and 2 mothers), Roman Catholic (2 fathers and 3 mothers), and Christian (1 father and 1 mother). This is not dissimilar to the full retrospective sample in which the majority of parents were born in the UK and Ireland (55%) and 61% of the parents for whom the case files reported religious affiliation were Jewish.

4.5.2 Parental psychiatric history:

a. Parents' psychiatric diagnoses and psychiatric history

Within the follow-up sample, more than half of the subjects' (56%) parents were diagnosed as having suffered from a psychiatric disorder. In DSM terms, diagnoses were primarily taken from Axis I. The files of eight additional follow-up subjects included information related to parental psychiatric history, although this information was not necessarily sufficient to diagnose a psychiatric disorder. By far the most common parental symptomatology related to depressive symptoms followed by anxiety disorders. This is in keeping with the findings from the full retrospective sample. Drug and addiction problems as well as criminal behavior were relatively rare. Appendix 4.19 presents the frequency of psychological problems among parents for the full retrospective and follow-up samples. The number of patients in each diagnostic group was too small to permit a statistical comparison of the two samples. Visual exploration of the figures presented in Appendix 4.19 reveal a slightly higher percentage of depressive (predominantly post-partum) and anxiety disorders in the follow-up sample.

b. Parent's global functioning (GAF scores)

The retrospective study also assessed the overall severity of parents' psychiatric disturbance through the use of the Global Assessment of Functioning Scale (GAF; see Moos et al., 2002). Functioning levels are rated as follows: 100-91 = excellent functioning; 90-81 = good functioning, 80-71 = adequate functioning, 70-61 = mildly impaired functioning, 60-51 = moderately impaired functioning, 50-41 = significantly impaired functioning, 40-31 = severe impairment of functioning, 30-21 = gross

disturbance of functioning, 20-11 = very poor and dependent functioning, and 10-1 = minimal psychological functioning.

Within the follow-up sample, mothers' GAF scores ranged from 52-81 (n=33) with an average GAF score of 69.64. Fathers' GAF scores ranged in from 25-85 with an average of 64.18 (n = 31). As can be seen in Table 4.2, none of the parents in either sample had GAF scores in the excellent functioning range (i.e., 91-100). The majority of parents in both the retrospective and follow-up samples tended to have GAF scores in the 51-80 range, indicating a level of functioning that does not fall below moderate impairment. The non-parametric analysis of trends yielded no significant differences in the distribution of Mothers and Fathers GAF scores between the two samples. For both samples, frequencies are presented relative to the number of subjects for whom this data was available.

Table 4.2. Distribution of mother and father GAF scores

GAF score range	**% of mothers retrospective sample (n=627)**	**% of mothers follow-up sample (n=33)**	**% of fathers retrospective sample (n=527)**	**% of fathers follow-up sample (n=31)**
1-10				
11-40	1.7% (n = 11)			3.2 (n = 1)
41-50	3.0 (n = 19)		2.4 (n = 13)	
51-60	19.7 (n = 124)	21.2 (n = 7)	19.1 (n = 101)	19.3 (n = 6)
61-70	43.3 (n = 271)	30.3 (n = 10)	32.2 (n = 170)	22.5 (n = 7)
71-80	31.7 (n = 199)	45.4 (n = 15)	34.5 (n = 182)	38.7 (n = 12)
81-90	6.5 (n = 41)	3.0 (n = 1)	11.0 (n = 58)	16.1 (n = 5)
91-100				
Kendal's S test	S=2166 z=1.01	p=.156	S=1254 z= .755	P=.222

* $p < .05$.

4.5.3 Child and clinical variables:

a. Age at start of treatment

The distribution of subjects' age at referral was roughly comparable for the follow-up and full retrospective samples, with no significant differences between the two. 20.5% of the follow-up subjects (n = 7) were under 6 years of age at referral as compared to 23% of the full sample (n = 175), 38.2% follow-up subjects (n = 13) were between 6-9 years of age as compared to 33.7% of the full sample (n = 257), 26.4% of the follow-up subjects were between ages 10-14 (n = 9) as compared to 28.9% of the full sample(n = 221), and 14.7% of the follow-up subjects were over 14 (n = 5) as compared to 14.4% of the full sample (n = 110). Among the follow-up subjects, the average age at the start of treatment was 9.78 years, ranging from 3.75 to 17.67 years. The non-parametric trend test revealed no differences between the groups. The distribution of age at referral for both sample groups is presented in Appendix 4.20.

b. Intellectual Functioning

The distribution of overall IQ scores for both the follow-up (n=27) and retrospective samples (n =763) was similar with no significant differences between the two. In both samples, the distribution of IQ scores was skewed towards average and above average intelligence. Approximately a quarter of both samples received IQ scores of 126 or above, one-third of both samples received IQ scores in the 111-125 and 91-110 ranges, and roughly 7-8% received scores below 90. The non-parametric test of trend revealed no differences between these distributions. Appendix 4.21 presents the distribution of IQ scores for both samples and the results of the trend test.

c. Presenting symptomatology and global functioning

Type of psychiatric disturbance

Table 4.3 presents a breakdown of the primary psychiatric diagnoses assigned to the follow-up and retrospective study subjects. In both samples, anxiety disorders are the most frequent principal diagnosis, followed by depressive disorders. However, in the follow-up sample, nearly half the subjects were diagnosed with an anxiety disorder as

opposed to 25% in the full sample. With regard to depressive disorders, roughly twice as many were represented in the full sample as compared to the follow-up group. The same pattern is true of the disruptive disorders. Of the 31 follow-up subjects who met criteria for a DSM diagnosis in childhood, 28 (90%) presented with comorbid disorders ranging from 1-11 in number. On average, the follow-up sample suffered from an average of four DSM disorders at referral, indicating the severity of their disturbance. Subjects presented a mixed combination of disorders. A quarter of those with multiple diagnoses (7 out of 28) suffered from both emotional and behavioral disorders. The majority presented with mixed emotional and developmental disorders, or a combination of emotional and pervasive developmental, personality or other childhood disorders. Chi-square tests (see Table 4.3) revealed that the two samples differ significantly with regard to the prevalence of two groups of disorders. These include the group of pervasive developmental and psychotic disorders and a heterogeneous class of disorders specific to childhood, both of which were more common in the follow-up sample. However, the problem of multiple comparisons and small cells with expected frequencies below 5 suggests that the difference is likely to be due to chance.

Table 4.3. Principal psychiatric diagnoses of children referred for treatment

Diagnostic category	**% in retrospective sample (n = 763)***	**% in follow-up sample (n = 34)**	**Chi-square (df=1)**	**Exact probability**
Anxiety disorders	25.4 (n = 194)	47.0 (n = 16)	2.75	0.0970 n.s.
Depressive disorders	10.5 (n = 80)	5.8 (n = 2)	0.75	0.3874 n.s.
Disruptive disorders (Conduct and ADHD)	11.3 (n = 86)	5.8 (n = 2)	0.96	0.3266 n.s.
Pervasive developmental disorders and psychoses	4.3 (n = 33)	11.7 (n = 4)	4.07	0.0437
Enuresis	4.8 (n = 37)		1.73	0.1885 n.s.
Encopresis	2.5 (n = 19)	2.9 (n = 1)	0.03	0.8693 n.s.
Other specific childhood disorders (developmental, tics, mutism)	4.5 (n = 46)	14.7 (n = 5)	4.09	0.0431
Personality, attachment and stress disorders	3.2 (n = 24)	2.9 (n = 1)	0.00	0.9467 n.s.
No diagnosis	7.3 (n = 56)	8.8 (n = 3)	0.10	0.7464 n.s.
Insufficient information	7.3 (n = 56)		2.68	0.1014 n.s.

* Frequencies regarding the full retrospective sample (Target, 1993) add up to 82.6%.

School difficulties

Seventy-three percent (n = 25) of the follow-up subjects (73%) experienced some type of difficulty at school as compared to 64% of the full retrospective sample (n = 488). Table 4.4 presents a breakdown of the types and frequencies of school difficulties present in the two samples. As can be seen, underachievement represented the largest and similar percentage of school difficulties in both groups. The chi-square analyses yielded only one significant difference in the distribution of the two samples' frequency and type of learning difficulties. Unfortunately, this difference reflected the higher than expected percentage of 'Other' (nos) school difficulties in the follow-up sample. In combination with multiple cells with lower than analyzable expected frequencies, the observation of the difference is hard to interpret.

Table 4.4. Frequencies of school difficulties

Type of difficulty	**% of retrospective sample (n = 763)**	**% of follow-up sample (n = 34)**	**Chi-square (df=1)**	**Exact probability**
School refusal	7.0 (n = 53)	2.9 (n = 1)	0.83	0.3633 (n.s.)
Disabling anxiety	4.0 (n = 30)	5.8 (n = 2)	0.32	0.5708 (n.s.)
Specific learning disability	14.2 (n = 108)	20.5 (n = 7)	1.09	0.2962 (n.s.)
Underachievement	26.0 (n = 198)	26.4 (n = 9)	0.00	0.9460 (n.s.)
Poor peer relations	15.5 (n = 118)	11.7 (n = 4)	0.34	0.5576 (n.s.)
Disruptive behavior	10.0 (n = 76)	5.8 (n = 2)	0.61	0.4336 (n.s.)
Other	2.0 (n = 15)	14.7 (n = 5)	21.59	0.0000

HCAM level

The follow-up subjects had an average HCAM score of 57 points at assessment, well beneath the functioning cut-off of 70. HCAM scores ranged from 41-83 with only two subjects having a score in the functional range (above 70). Based on the non-parametric trend test analysis, the distribution of HCAM scores in the follow-up sample did not differ significantly from the retrospective sample (S=820, z=.33, p=.37). The distribution of both samples' assessment HCAM scores is presented in Appendix 4.2224

4.5.4 Referral and Treatment Variables:

a. Session frequency: Intensive versus non-intensive treatment

The majority of subjects in both the follow-up and retrospective samples received intensive treatment with a frequency of 4 to 5 sessions per week, whereas the minority of subjects received non-intensive psychotherapy of 1 to 3 sessions per week. Differences in frequency of sessions between the two groups were not significant (see Appendix 4.23 for chi-square analysis).

b. Length of treatment

Overall, the follow-up subjects received long-term treatment at the AFC. Treatment lasted for an average of 2.84 years, ranging between 0.75 and 6.08 years. Only one subject had less than a year of treatment. The difference between samples was significant on the non-parametric trend test (S=8561, Z=3.967, p=0.0000). The distribution of length of treatment is presented in Table 4.5 below. However, it is important to point out that subjects who received less than six months of treatment were excluded from the follow-up study.

Table 4.5. Distribution of length of treatment

Length of treatment	**% of retrospective sample (n = 763)**	**% of follow-up sample (n = 34)**
Under 1 year	29.2 (n = 223)	2.8 (n = 1)
1-3 years	48.2 (n = 368)	55.8 (n = 19)
3-5 years	15.7 (n = 120)	35.2 (n = 12)
Over 5 years	6.9 (n = 53)	5.8 (n = 2)

c. Work with parents parallel to child treatment

In both the full and follow-up samples, approximately half of the parents received parent guidance before and/or during their child's treatment. Table 4.6 presents the distribution of treated children whose parents received guidance or treatment at the AFC. A chi-square analysis revealed that a significantly higher percentage of follow-up subjects' parents received non-intensive psychotherapy or psychoanalysis than their retrospective sample counterparts.

Table 4.6. Percentage of children whose parents received guidance or treatment

Type of intervention	**Parent guidance**	**Non-intensive psychotherapy**	**Psychoanalysis**
% of retrospective sample	49.2 (n = 375)	4.4 (n = 33)	3.9 (n = 30)
% of follow-up sample	50.0 (n = 17)	11.7 (n = 4)	11.7 (n = 4)
Chi-square (df=1)	0.01	4.07	4.89
Exact probability	0.923 (n.s.)	0.044	0.027

d. Reason for termination of treatment

A chi-square analysis yielded significantly different distributions between the two groups regarding the reasons underlying the termination of treatment (χ^2 = 112.79, sd = 4, p < .01). A higher percentage of treatments in the follow-up (n=30) group were terminated by mutual agreement as compared to the full retrospective sample (47% versus 36%). In addition, more treatments in the full sample were terminated prematurely by parents or child as compared to the follow-up sample (30.3% versus 14.7%). The observed difference is probably accounted for by the exclusion of participants with less than 6 months of treatment from the follow-up sample. Table 4.7 presents the reasons underlying treatment termination for both samples.

Table 4.7. Distribution of reasons for treatment termination

Primary reason for termination	**% of retrospective sample (n = 763)**	**% of follow-up sample (n = 34)**	**Chi-square (df=4)**	**Exact probability**
Mutual agreement	36 (n = 275)	47 (n = 16)	117.24	0.0000
Premature termination by parents or child	30.3 (n = 231)	14.7 (n = 5)		
External circumstances of therapist or family	18.7 (n = 143)	14.7 (n = 5)		
Other	15.1 (n = 115)	8.8 (n = 3)		
Unknown		14.8 (n = 5)		

e. Termination Variables

The retrospective study (Target, 1993) evaluated the effectiveness of treatment on the basis of several criteria. First, subjects were no longer considered a 'case' when they did not meet criteria for a DSM diagnosis at termination and had a termination HCAM score of 70 or above. Second, treatment was considered effective if termination HCAM scores were no longer dysfunctional (i.e., equal or less than 68 points). Third, an increase in eight or more points from referral to termination HCAM levels was seen as indicative of reliable improvement. A comparison of the follow-up and retrospective samples termination status is presented in Table 4.8. For the retrospective sample, only subjects who received at least six months of treatment are included. Because information was insufficient to determine termination HCAM scores and/or termination diagnoses for many of the follow-up subjects, 'caseness' for this sample is not reported. None of the available outcome data showed significant discrepancy between the full sample and follow-up subset.

Table 4.8. Percentage of cases showing improvement at termination, according to different criteria

Diagnostic Criteria	**% of retrospective sample**	**% of follow-up sample**	**Chi-square (df=1)**	**Exact probability**
HCAM level same or worse	20.1 (n = 153)	18.5 (n=27)	0.08	0.7823
HCAM level functional (above 68 points)	53.7 (n = 410)	62.9 (n=27)	0.89	0.3444
Reliable improvement in HCAM (8 or more points)	59.3 (n = 452)	62.9 (n = 27)	0.32	0.5694

n.s.

The representativeness of the follow-up sample

Given the relatively small size of the follow-up sample (n=34), and the non-random way in which participants were selected, it was important to examine the extent to which it is representative of the larger retrospective sample (n=763) from which it was drawn. For almost all the variables, the follow-up subjects appear to be fairly representative of the retrospective sample. Chi-square and non-parametric trend analyses revealed that the two samples had similar distributions regarding the demographic and family background variables. In both samples family structure, ethnic and religious background, and socio-economic levels are comparable. As was the case in the retrospective study, patients tended to come from higher socio-economic levels than what is expected in the general population. So, too, both samples include a disproportionate percentage of Jewish families than one would expect in outcome studies. These factors limit the findings of both the retrospective and the follow-up study to general outcome populations. In addition, the two samples shared similar distributions regarding IQ levels and global levels of functioning at assessment (HCAM score). Similarly, the subjects' age at start of treatment and relative length of treatment were comparable.

Because of the small sample followed up, statistical comparisons are of limited value as the tests were mostly not powerful enough to detect differences between the groups. There are, however, several findings that cautiously suggest that the follow-up study may be a slightly more advantageous group than the overall sample. First, although the samples did not differ significantly regarding family background variables, none of the follow-up subjects were raised in foster homes, long-term hospital care or reconstituted families. In addition, the lower ends of parental GAF scores and child HCAM scores were under-represented in the follow-up sample. This difference was particularly significant with regard to the distribution of fathers' GAF scores. A further point relates to the significantly different distribution of primary presenting diagnoses. The follow-up subjects were diagnosed with a relatively higher prevalence of anxiety disorders (47%) in contrast to the prevalence of anxiety disorders in the full sample (25.4%) and to prevalence rates of 8-12% reported in epidemiological studies (Keller et al., 1992; Majcher & Pollack, 1996; McGee et al., 1990). Given that fewer anxious children are referred for treatment than children with disruptive disorders (Beardsley et al., 1997; Beidel & Turner, 1997), the high prevalence rate in the current sample is somewhat

unusual. This is a potentially meaningful difference given that anxiety disorders tend to respond better to treatment than disruptive disorders (Fonagy & Target, 1994, 1996; Target & Fonagy, 1994a), and also serve as a protective factor against the long-term persistence of disruptive disorders when co-occurring with them (Loeber & Keenan, 1994; Vander Stoep, Weiss, McKnight, Beresford & Cohen, 2002). Although the long-term trajectory of childhood anxiety disorders is not yet fully understood (see section 1.2.1.b), the disproportionate prevalence of anxiety disorders within the current sample may have skewed their adult outcome in a more positive direction. Taken together, these factors seem to point to a sample whose background is somewhat better off than the full AFC retrospective sample and more advantageous than most outcome samples.

A final point of interest relates to the questions raised in section 4.3.3 regarding the underlying motivation of those subjects who actively chose to participate in the follow-up study. In nearly half of the follow-up cases, (as opposed to 36% of the full sample) the decision to terminate treatment was based on a mutual agreement between therapist and family. A chi-square analysis indeed yielded significant differences between the two groups for the distribution of this variable. A few authors have reported that treatments identified as 'completed' by analysts and terminated by mutual agreement are associated with greater benefit to patients (Bachrach, 1993; Rudolf, 1991; Sashin et al., 1975). Perhaps, then, at least half the sample represent 'satisfied customers' who were happy to participate in the AFC study out of a sense of gratitude for the beneficial help they received in childhood. Moreover, the significant difference between the two samples regarding the frequency and type of help parents received may have created a family environment in which psychological treatments are viewed in a positive light. Half of the follow-up sample's parents received parent guidance and nearly 12% received either psychoanalysis or non-intensive psychotherapy at the AFC (in contrast to approximately 4% in the full sample). This cultural acceptance of psychotherapy and, perhaps, psychoanalysis in particular, may explain part of the self-selection process motivating these individuals to participate in the follow-up study.

4.6 CONCLUSIONS

This chapter describes the background to the AFC long-term follow-up study of adults treated in childhood. The study aims at investigating the long-term trajectory of childhood disturbance and the effects of psychodynamic treatment in childhood on adult adjustment. The study fills a gap in the current literature by assessing treatment in a naturalistic setting, focusing specifically on psychodynamic treatments which have received scant attention, and by following up a high risk sample many years beyond the conclusion of treatment in childhood. Moreover, the study contributes a unique interview protocol which assesses symptomatology, functioning across a wide range of domains, as well as psychodynamic constructs relevant to this particular form of treatment. A detailed description of the interview protocol and its development is presented. Finally, the childhood background of the thirty-four subjects who participated in the follow-up study is presented in relation to the original and much larger retrospective sample. On the whole, the follow-up sample is fairly representative of the full sample, although characterized by a slightly more advantageous background. The representativeness of both samples and the generalizability of their findings are discussed in relation to typical outcome studies.

CHAPTER 5. THE ADULT OUTCOME OF CHILDHOOD PSYCHOANALYSIS

This chapter introduces the adult outcome of 34 individuals who were treated in childhood at the AFC and who were 'caught up' with in adulthood for participation in the long-term follow-up study. Based on the recommendations of epidemiological and psychotherapy outcome research, the study aims to fill several gaps in the existing literature. First, the study focuses on a group of individuals treated in a naturalistic clinical setting, as opposed to a laboratory research context. Moreover, the subjects presented for treatment in childhood with complex and co-occurring disorders in contrast to single disorders investigated in most outcome research. In addition, the study examines psychodynamically–oriented therapy which although highly prevalent in clinical practice is grossly under-represented in outcome research. In particular, the study assesses the long-term outcome of early childhood disturbance in order to evaluate the cost-effectiveness of intensive intervention in childhood for long-term adult functioning. Finally, in keeping with the study's aims, adult outcome is assessed according to multiple parameters, including psychiatric symptomatology and diagnosis as well as adaptive functioning across multiple domains and skills.

The chapter is comprised of four main sections. In the first section, data regarding the subjects' adult demographic background is presented. This is followed by a summary of the central findings from the adult outcome measures. The third section introduces the Adult Functioning Index (AFI) which offers an alternative approach to the global assessment of adult outcome. Traditionally, outcome research has tended to assess individuals either in terms of psychiatric diagnosis and/or through the use of psychosocial assessment scores. In contrast, the AFI represents an attempt to integrate both symptomatology and adaptation into a more comprehensive and integrated global score. The AFI is then examined in relation to the adult demographic data and the outcome findings presented in the first two sections. Finally, the chapter explores the relationship between adult functioning and attachment in light of the current study's findings and other recent research.

5.1 ADULT DEMOGRAPHIC BACKGROUND

Age distribution

The 34 adult follow-up subjects who were treated in childhood at the AFC were comprised of 15 male and 19 female subjects. Inclusion criteria required that subjects be from a roughly comparable stage in adult life, defined as early to mid-adulthood (25-50 years of age). At the time the adult interviews were conducted, subjects ranged between the ages of 29.5 and 46.6 years of age, with an average age of 36.6 years. The majority of subjects were in their 30's (n = 20) with roughly comparable numbers in the 20 and 40 age groups (six and eight respectively).

Intelligence scores distribution

Full IQ scores based on the NART verbal intelligence test ranged from 100-127, with an average IQ score of 118. All subjects (n = 33) received average or above average IQ scores, with the overwhelming majority receiving above average scores. Twenty-seven subjects had IQ scores of 126 or higher, two had scores in the 111-125 range, and four had scores in the 91-110 range. As in childhood, the distribution of IQ scores in adulthood is skewed towards above average intelligence and is not representative of most outcome study populations.

Socio-economic status

The participants' socio-economic status was assessed using the Hope-Goldthorpe Occupation Ratings scale (see Appendix 5.1). Overall, the subjects' current socio-economic status (SES) was middle to upper class. For the 31 subjects for whom SES information was obtained, the majority (23 or 74%) was ranked in the middle to upper class grouping, with only eight subjects (26%) falling in the working class group. Of these eight, five were ranked in the lowest socio-economic bracket (16%). The majority of subjects (82%) were employed in part or full-time work at the time of interview. Six subjects were unemployed, including two men, three women engaged in full-time care of their children, and one physically disabled woman. As in their childhood, the subjects' socio-economic status is skewed to the higher end of the spectrum.

Social support and parent status

Nineteen of the subjects (56%) were involved in a long-term, cohabiting relationship (above six months) as opposed to 15 who were single, living on their own or, alternatively, with flat-mates or parents. So, too, 19 of the subjects (56%) were parents. Of these 19 subjects, three were not in cohabiting relationships: two were 'single moms' raising children on their own, and one was a divorced father whose children live with their mother. The majority of subjects (85%) reported having a close friend or confidant to whom they could turn for practical and emotional support, most or all of the time. Two subjects reported a complete lack of this type of support and three felt they could turn occasionally to such a confidant. Thus, for the most part, follow-up subjects reported the presence of supportive relationships either in the form of intimate relationships and/or close friendships.

In sum, the subjects who comprise the follow-up sample are predominantly in their 30's, with roughly equal numbers in their 20's and 40's, thus meeting the aim of the study to catch up with individuals who were treated in childhood at the AFC and who are now in early to mid-adulthood. As was true of their childhood background, the follow-up sample is skewed in terms of overall intelligence scores and socio-economic status, both of which are above average. The majority of subjects reported the presence of at least one support figure, either a cohabiting partner and/or a friend. This is an important demographic factor given the known relationship between social support, psychopathology and adversity (Champion, 1990; Champion & Goodall, 1993; McCarthy & Taylor, 1999; Rutter, 1990).

5.2 ADULT OUTCOME ACROSS DOMAINS AND MEASURES

In this section, the central findings from the follow-up study are presented in keeping with the types of measures and domains described in section 4.2.2.

5.2.1 Adult psychopathology and use of mental health services

The prevalence of adult mental health problems was assessed according to DSM Axis I (SADS-L, Appendix 4.1) and Axis II (SCID-II, Appendix 4.2) disorders. In addition, personality disorders were also assessed by the SWAP-200 PD and Q-score profiles (Appendix, 4.3).

a. The prevalence of adult DSM Axis I psychiatric disorders

Approximately 62% of the follow-up subjects met criteria for one or more Axis I diagnoses during adulthood. Ten subjects met criteria for at least one current Axis I diagnosis, ranging from one to three in number, and 20 had met criteria for past adult diagnoses, ranging from one to seven in number. Of these, nine subjects were chronic sufferers, meeting criteria for both past and present psychiatric disorders, sometimes for multiple and simultaneous disorders. Table 5.1 presents the lifetime prevalence and type of Axis I disorders diagnosed in this sample as well as prevalence of past and current comorbidity. As can be seen, Major and Minor Depression were the most frequently assigned diagnoses followed by anxiety and phobic disorders. Diagnostic criteria for Bipolar Disorder, the psychotic disorders and Post-Traumatic Stress Disorder were not met by any of the follow-up subjects.

Table 5.1. Distribution of past and current, single and comorbid adult psychiatric disorders

Type of disorder	No. of diagnoses	Past and current episodes	Past episode only
Anxiety disorder	5	1	4
Panic disorder	3	2	1
Phobic disorder	5	4	1
Obsessive-compulsive disorder	2	1	1
Major depression	8	2	6
Minor depression	8	1	7
Dysthymia	3	2	1
Hypomanic disorder	2	0	2
Bipolar disorder	0	0	0
Cyclothymia	1	0	1
Drug abuse	3	0	3
Schizophrenia	0	0	0
Schizoaffective disorder	0	0	0
Unspecified psychosis	0	0	0
Drug dependence	2	0	2
Anorexia	1	1	0
Bulimia	1	1	0
Adjustment disorder	1	1	0
Post-traumatic stress disorder	0	0	0
Comorbidity		**Current diagnoses**	**Past diagnoses**
No. of subjects with 0 diagnoses		24	14
No. of subjects with 1 diagnosis		6	6
No. of subjects with 2 diagnoses		3	8
No. of subjects with 3+ diagnoses		1	6

b. The prevalence of DSM Axis II adult personality disorders

Only three subjects met Axis II criteria for a current diagnosable personality disorder (PD), based on the SCID-II. Indeed, these same three subjects met criteria for multiple PDs ranging from two to six in number. In addition, 16 subjects were diagnosed as 'sub-threshold' for one or more PDs, ranging in number from one to eight. The three subjects who met criteria for a PD were also rated sub-threshold for other PDs. Table 5.2 presents the type and comorbidity of PDs rated as diagnosable or sub-threshold.

Table 5.2. Prevalence of SCID-II personality disorders (PDs)

Personality disorder	**Diagnosable**	**Sub-threshold**
Avoidant PD	2	4
Dependent PD	1	1
Obsessive-compulsive PD	0	9
Passive-aggressive PD	0	3
Self-defeating PD	0	1
Paranoid PD	2	2
Schizotypal PD	2	1
Schizoid PD	0	1
Histrionic PD	1	3
Narcissistic PD	1	4
Borderline PD	2	3
Antisocial PD	0	1
PD NOS	0	0
Comorbidity	**PDs**	**Sub-threshold**
No. of subjects with 0 diagnosis	31	16
No. of subjects with 1 diagnosis	0	13
No. of subjects with 2 diagnoses	1	1
No. of subjects with 3+ diagnoses	2	4

c. The prevalence of SWAP-200 PD Q-Score profiles

Professional dissatisfaction with the DSM Axis II personality disorder diagnostic system has been expressed increasingly in recent years. Criticism focuses on its poor test-retest reliability (Blatt & Levy, 1998; Westen & Shedler, 1999a) and low validity (Hill et al., 1995; Westen & Shedler, 1999b). Particularly troubling is its lack of discriminant validity evidenced by the fact that most individuals who meet criteria for a PD tend to receive multiple PDs as well as frequent Axis I diagnoses (Blatt & Levy, 1998; Nathan, 1998; Shedler & Westen, 1998). In response to these criticisms, Shedler and Westen devised the SWAP-200 which generates both Axis II-based and new personality Q-score profiles (see section 4.2.2.a.3). In keeping with the authors' instructions, inter-rater reliability ratings between 3 pairs of raters were conducted for 31of the follow-up subjects (n=31) and 11 additional subjects later excluded from the study. Initial reliability ratings for the full sample (n=50) achieved an average Spearman correlation coefficient of .60. Subjects whose reliability ratings were below .65 were re-rated following conferencing, leading to an improved average reliability for the full sample (n=50) of .76. This is in keeping with the authors' reporting of Pearson reliability ratings of .75. Initial low reliability ratings for some of the subjects can be explained by the relative clinical inexperience of two of the three raters, the use of audio-taped rather than video-taped interviews, and the time lag between the actual interview and its rating.

PD profiles

Initially, Shedler and Westen (Westen & Shedler, 1999a, 1999b) considered a PD T-score above 70 to be indicative of a PD diagnosis. In the current sample, none of the subjects met this criterion. More recently, the authors (private communication, 2003) suggested that a lower cut-off be used for outpatient samples, given that their original study diagnosed very disordered individuals. In the follow-up sample, a cut-off of 60 revealed six individuals with T-scores indicative of personality disturbance, four of whom received multiple PD diagnoses. Nine of the 12 DSM Axis II diagnoses were assigned once and Schizotypal PD was assigned to three individuals. Self-Defeating PD and PD NOS were not assigned to any of the subjects. The PD profiles can be seen in Appendix 5.2. Table 5.3 presents the average T-scores for Axis II PDs. As can be seen, average T-scores for all of the PDs were below 50 indicating a relatively undisturbed sample.

Table 5.3. Mean, standard deviation and range of personality disorder T-scores (n=31)

PD T-score	Mean	S.D.	Minimum T-Score	Maximum T-score
Paranoid	43.20	6.88	31.8	62.7
Schizoid	45.82	7.27	36.1	68.6
Schizotypal	45.21	8.79	32.7	65.5
Antisocial	46.41	5.38	37.2	62.4
Borderline	41.66	10.01	26.6	63.7
Histrionic	45.60	7.47	32.4	64.3
Narcissistic	46.65	5.69	36.7	61.6
Avoidant	45.23	7.33	29.1	63.9
Dependent	45.60	8.14	26.5	57.9
Obsessive	49.96	6.62	38.1	61.1
Average T-score	45.53	4.29	39.6	55.1

Q-score profiles

The average T-scores of the new PD groups also fell below the 60-point cut-off with the exception of the 'Obsessional' category (T = 60.72). All of the new PD categories were assigned at least once, ranging from one to four individuals; the 'Dependent' category was not assigned to any of the subjects. The most frequently assigned categories were 'High-functioning depressive' (17 subjects received a T-score between 60-70 points and one above 70) followed by 'Obsessional' (eight subject received a T-score between 60-70 points and eight above 70). However, the authors reported difficulties distinguishing between these two categories and a more general high functioning factor or 'health index' (personal communication, 2004). Thus, it is likely that these two categories are not indicative of personality dysfunction. Table 5.4 presents the average T-scores for the

new PD categories (Q-score profiles can be seen in Appendix 5.3). For purposes of this discussion, Q-scores between 50 and 60 are referred to as sub-threshold and scores above 60 are considered above threshold or indicative of diagnosis.

Table 5.4. Mean, standard deviation and range of T-scores for new SWAP Q-score PD profiles PD (n=31)

New PD T-score	Mean	S.D.	Minimum T-score	Maximum T-score	No. of subjects with 50-60 Q-score	No. of subjects with 60+ Q-score
Dysphoric	46.15	7.79	26.80	60.08	10	1
Antisocial	46.86	5.00	37.71	60.91	6	1
Schizoid	46.73	7.52	35.29	66.03	4	3
Paranoid	44.60	7.52	31.35	68.89	5	2
Obsessional	60.72	10.64	33.38	76.92	10	16
Histrionic	50.92	6.96	40.19	65.75	14	5
Narcissistic	45.40	8.17	30.04	64.70	4	2
Avoidant	47.51	6.13	36.97	71.25	11	1
High-Functioning Depressive	59.00	8.22	39.73	68.09	8	18
Emotionally Dysregulated	42.52	11.01	25.26	58.51	7	2
Dependent	42.44	7.66	25.70	60.38	5	0
Hostile	46.54	6.77	31.42	52.30	8	1
Average T-score	48.58	2.06	44.81	50.30		

d. Use of mental health services since childhood

One criterion for evaluating the cost-effectiveness of early treatment in childhood is the extent to which the follow-up subjects made contact with mental health or other professionals for help with emotional difficulties in adulthood. Based on the SADS-L measure, 50% of the current sample (n = 17) had sought professional help for 'nerves' or 'emotional problems' during adulthood. Thirteen subjects made contact with mental health professionals and four consulted with other professionals, such as general practitioners, social workers, etc. Professional contact tended to be brief (one or two sessions) for nine subjects, two individuals received treatment for up to one year, and six participated in treatment for more than one year. Just over a quarter of the sample (n = 9) was prescribed medication for emotional difficulties, including sleeping tablets, sedatives, major tranquilizers, anti-depressants and lithium. Only two subjects were hospitalized for psychological problems, one at age 32 for less than five days and the other for a total of 18-24 months on four occasions due to severe anorexia during her early twenties. For most subjects, professional consultations in adulthood tended to occur while subjects were in their 20's, suggesting early adulthood as a particularly vulnerable stage.

Recent epidemiological studies estimate the lifetime prevalence rates of adult mental disorders to be between 30% and 50% (Bijl, Ravelli, & van Zessen, 1998; Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen & Kendler, 1994; Kringlen, Torgesen & Cramer, 2001). A recent large-scale epidemiological investigation of the prevalence of mental disorder in Oslo, Norway, for example, reported a lifetime prevalence rate of 52.4% among a random sample of 18 to 65 year-olds (Kringlen, Torgesen & Cramer, 2001). In the Oslo study, alcohol abuse, depression and phobias were the most frequent mental disorders. In contrast, the follow-up sample had a lifetime prevalence of 62% reflecting a somewhat higher rate than those reported for general adult populations. In addition, cases of drug/alcohol abuse were relatively infrequent in the follow-up sample. Relative to long-term studies that investigated the outcome of child and adolescent psychiatric disorders (Larsen, Dahl & Hallum, 1990; Ostman, 1991; Steinhausen, Meier & Angst, 1998), the current sample reported much lower rates of admission to or use of adult psychiatric services. Given the small sample size and possible rating biases toward the depressive disorders, it is difficult to conclude

whether prevalence rates for the follow-sample are comparable to or somewhat higher than that of the general adult population. However, the low frequency of personality disorders and the relatively limited use of psychiatric services in adulthood may indicate a less chronic and milder level of mental disorders within the follow-up sample.

5.2.2 Physical health and use of medical services

Less than 20% (six subjects) of the sample reported regular visits to medical practitioners due to physical disorders. The majority (74%) reported occasional visits for minor problems and three subjects had not been to their general practitioner at all during adulthood. A third of the sample had made only one or two visits to outpatient clinics and less than a quarter had been on three or more occasions. In addition, only four subjects had been admitted to hospital for something other than childbirth or minor surgery.

This general state of good physical health is further supported by data obtained from the SF-36 general health questionnaire (see Appendix 4.4) regarding the subjects' health in the four weeks preceding completion of the questionnaire. The SF-36 scores are standardized with higher scores indicating a better health state. As can be seen in Table 5.5, subjects' general health, physical functioning and associated impairment (role functioning – physical), and social functioning received mean scores above 75 reflecting relatively good health and physical and social functioning. The sample was relatively free of bodily pain but reported somewhat lower levels for mental health and emotional functioning. The mental health scale focuses specifically on anxious and depressive feelings and role functioning impairment due to emotional difficulties. The majority of subjects (79.37% - social functioning), however, did not feel that either their physical or emotional difficulties had interfered with their normal social activities.

Table 5.5. The mean, range and standard deviation of the 8 SF-36 health scales

SF-36 Health Scales	N	Minimum	Maximum	Mean	S.D.
Physical Functioning	28	5	100	88.73	20.86
Role Functioning - Physical	28	0	100	77.68	34.92
Bodily Pain	28	0	100	71.20	30.93
General Health	28	10	100	75.07	22.23
Vitality	28	0	95	55.54	20.74
Social Functioning	28	25	100	79.37	23.56
Role Functioning- Emotional	28	0	100	63.01	39.93
Mental Health	28	16	96	69.37	21.23

Thus, as a group, the follow-up sample seems to have relatively good physical health, with somewhat greater mental health difficulties. Emotional difficulties do not seem to lead to significant social impairment (social functioning, 79.37%) but are associated with a slightly lower level of productivity (role functioning – emotional, 63.0%).

5.2.3 Adult functioning, planning abilities and coping skills across domains

In keeping with the study's aims described in Chapter 4, adult outcome was assessed not only in terms of psychiatric diagnoses but also in terms of functioning and adaptation across a range of domains and skills.

a. Adult functioning across domains

Adult outcome assessed by the APFA yielded an average functioning score of 17.5 which is just inside the functional end (6-18) of the full range of 6-36 (best to worst functioning). Four of the six individual sub-scales yielded an average score within the adaptive end of the score range (1-3, best to worst). These included the Coping, Negotiations, Non-Specific Social Contacts and Friendship domains. In contrast, the

Work and Love domains received average functioning scores outside the adaptive range. The distribution of APFA scores according to domain and the average APFA functioning scores are presented in Table 5.6.

Table 5.6. Distribution of subjects' functioning levels according to APFA domains

	Love	**Work**	**Friends**	**Non-specific social contacts**	**Negotiations**	**Coping**
1 = Remarkable	0	0	0	0	1	0
2 = Good	7	14	16	18	21	26
3 = Adequate, but some concern	12	10	8	6		2
4 = Significant difficulties with background of adequate functioning	3	3	5	6	5	2
5 = Like 6 but with some significant functioning	8	1	3	3	4	2
6 = Functioning dominated by discord, disorganization and conflict	3	1	1	0	1	0
Total no. of subjects (n)	33	29*	33	33	32*	32*
Overall APFA score	**Number of subjects**			**Minimum-maximum score range**		
Functional score (6-18)	23			8 - 18		
Dysfunctional score (19-36)	10			19 - 35		

* The Work domain could not be rated for three female subjects involved in full-time care of young children and for one woman suffering from severe physical disability. For these subjects a rating of 'lack of opportunity' ('8') was assigned. The Negotiations and Daily Coping domains could not be rated for two subjects due to poor quality of their interviews' audio-recording.

b. Planning and navigating transitions across domains

Subjects' ability to plan for and negotiate major transitions in three domains was assessed through the TAPI (see Appendix 4.6). Table 5.7 presents the distribution of planning scores for each domain. As can be seen, the overwhelming majority of subjects described definitely or possibly planned transitions in each of the three domains. Unclear planning or definite lack of planning was present in only a minority of cases.

Table 5.7. Distribution of planning scores for the three TAPI domains

TAPI rating	Education/Work (n=33)	Personal Relationships (n=32)	Independent Living (n=33)
1 = Definitely planned	9	9	15
2 = Possibly planned	20	11	11
3 = Passive planning	1	1	0
4 = Planning unclear	3	2	2
5 = Definitely unplanned	0	3	2
6 = Not applicable	0	6	3

c. Coping strategies across domains

Coping abilities were assessed across multiple domains in light of findings demonstrating that individuals do not cope uniformly in different settings (Folkman & Lazarus, 1980; Pearlin & Schooler, 1978). The Impact of Stress Interview (see Appendix 4.7) assesses coping in potentially four domains and also yields an overall coping score for each individual. Table 5.8 presents the subjects' overall and domain-specific coping scores. As can be seen, subjects' overall coping ratings were fairly evenly divided between 'good to excellent' and 'poor to very poor'. This was also the case for the

specific domains of intimate relations and family. In contrast, a higher proportion of subjects demonstrated 'good to excellent' as opposed to 'poor to very poor' coping skills in the work and friends domains.

Table 5.8. Subjects' average overall and domain-specific coping scores

Domain	Excellent (1)	Good (2)	Poor (3)	Very Poor (4)
Work (n=22)	7	9	3	3
Intimate relations (n=23)	2	10	9	2
Friends (n=11)	2	7	1	1
Family (n=24)	3	8	10	3
Other (n=3)		1		2
Overall coping (n=29)	3	12	10	4

5.2.4 The prevalence and degree of adversity in adulthood

The current study examined adversity in adulthood by means of the LEDS and the ALPHI measures (see section 4.2.2.e.1 and 4.2.2.e.2). Overall, the current sample (n = 33) experienced a relatively low level of stressful life events and difficulties and a mild degree of severe adversities across domains. On average, subjects reported 2.4 severe life events ranging between zero and ten in number. Seven subjects (21%) had not experienced any severe life events during the five years preceding the follow-up interviews. Similarly, less than half the sample (fifteen) experienced severe difficulties, ranging from 1-7 in number, during the same time period. This relative lack of stressors in the five years preceding the adult interviews seems be reflective of their entire adult life as depicted by their ALPHI scores which trace adversity from age 17 to the present.

Among the 32 subjects who were administered the ALPHI, only seven (22%) experienced adversities severe enough to receive a rating of 1 or 2 ('marked' or 'moderate') in any of the five ALPHI domains, during any of their adult life phases. The lack of very severe life events is further supported by the lack of PTSD diagnosis for any of the subjects.

5.2.5 Adult attachment and reflective functioning

In keeping with the study's aims described in Chapter 4, adult outcome was also assessed in terms of attachment status and reflective functioning, two potential moderators of adaptive behavior.

a. Adult Attachment Status

Subjects' attachment status was assessed by means of the AAI (see Appendix 4.8). In its original form, the AAI yields five potential classification groups: Secure (F), Insecure/Dismissing (Ds), Insecure/Preoccupied (E), Unresolved on loss and/or abuse (U), and Cannot Classify (CC). The distribution of subjects' attachment status is presented in Table 5.9. As can be seen, 38% of the sample was classified as securely attached whereas 68% was classified as insecurely attached (26% dismissing and 35% preoccupied). This distribution has a much smaller percentage of securely attached and a much higher percentage of unresolved/cannot classify individuals than that reported for low risk samples (Van IJzendoorn & Bakersman-Kranenburg, 1996). However, the follow-up sample has more than twice as many subjects with a secure attachment status than the average rate of 17% reported by Dozier and colleagues (1999) in their review of studies involving clinical samples. Given, the small number of subjects assigned to the E and CC classifications, subjects who were assigned either a 'U' or 'CC' primary classification were reassigned according to their secondary classification (F, D or E). For the remainder of this chapter, attachment will be discussed in keeping with the 3-way primary classification system. The breakdown for the current sample is 38% secure (n= 13), 26% dismissing (n=9) and 35% preoccupied (n=12).

Table 5.9. Prevalence of attachment classifications in follow-up sample compared to low-risk sample

Attachment classification	5-way classification	3-way classification	Low-risk sample distribution*
F - secure	12 (35%)	13 (38%)	56%
D – insecure dismissing	6 (18%)	9 (26%)	16%
E – insecure preoccupied	4 (12%)	12 (35%)	10%
U – unresolved loss/abuse	9 (26%)		18%
CC – cannot classify	3 (9%)		

* Data taken from Van IJzendoorn and Bakersman-Kranenburg, 1996.

b. Reflective functioning

Subjects received a mean RF score of 4.3, somewhat below the average RF score of 5. RF scores ranged between -1 and 8. Table 5.10 presents the distribution of RF scores. As can be seen, the majority of subjects' RF scores were low to definite, with few scores in either the very low or above average ends of the spectrum.

Table 5.10. Distribution of subjects' Reflective Functioning scores

RF rating	Number of subjects (n = 34)
-1 = negative RF	1
1 to 3 = absent but not repudiated RF	2
3 to 5 = questionable or low RF	15
5 to 7 = definite or ordinary RF	15
7 to 9 = marked RF	1
9+ = full or exceptional RF	0

5.3 THE ADULT FUNCTIONING INDEX

The previous section presented the individual findings of each of the adult outcome measures included in the follow-up study. In this section, a global index of adult functioning, namely the Adult Functioning Index (AFI), is presented. Descriptions of the AFI's rationale, composition and construction follow.

5.3.1 The rationale behind the AFI

As described in Chapter 4, a subsidiary aim of the follow-up study was to devise an interview protocol for a long-term follow-up study of adults treated psycho-dynamically in childhood. The goal was to develop a battery of interviews that would enable a comprehensive and multi-faceted description and assessment of adult functioning across a broad range of domains and skills. This is in keeping with current research practice that recommends the gathering of data from multiple sources covering a wide range of domains and perspectives (Verhulst & Koot, 1992). Multiple observations and perspectives not only provide a richer description of the subjects under investigation, but

also prevent biases inherent in individual approaches (Achenbach & McConaughty, 1997; Greenbaum, Dedrick, Prange & Friedman, 1994; Kashani, Orvaschel, Burk & Reid, 1985).

For the most part, outcome studies have relied heavily on symptom reduction as the primary criterion for evaluating treatment effectiveness (Fonagy et al., 2003). However, for psychoanalytic or psychodynamic treatments, reduction of symptoms alone is not considered sufficient evidence of treatment effectiveness. Rather, in-depth changes in an individual's underlying character or personality are seen as indicative of meaningful therapeutic change (Appelbaum, 1994; Frances, 1982; Sandler & Dreher, 1996; Sundin & Armelius, 1998; Werman, 1989). While measures of psychiatric illness and personality disorder clearly represent an important aspect of adult outcome, focusing solely on symptoms and diagnoses has several limitations even for non-psychodynamic approaches. First, measures of psychiatric and personality disturbance, such as the SADS-L and SCID-II, leave out important information regarding adaptive behavior and focus solely on impairment and dysfunction. Indeed, symptom measures tend to weigh heavily toward psychopathology, providing a sometimes imbalanced assessment. Moreover, symptom measures are only able to inform us about a treatment's impact on the subject's primary diagnosis. They do not, however, tell us anything about the individual's functioning either in general or in relation to specific domains. Furthermore, longitudinal studies on the outcome of childhood disorders show that long-term outcome is not well predicted by symptom severity alone (Robins & Rutter, 1990; Rutter, 1999). For these reasons, the follow-up assessment protocol was designed to include additional measures that enable an in-depth assessment of functioning across a range of domains and skills.

The question then arises regarding the best way to interpret and make use of a multi-level assessment. This is particularly challenging given the high degree of overlap between measures, leading to poor construct validity and inter-correlations between assessments. The DSM, for example, is based on a multi-axial assessment system in which individual axes are designed to assess unique and separate information about the patient (Moos et al., 2002). Axes I and II assess psychiatric illness and personality disorders respectively, while Axis V assesses the patient's highest level of adaptive functioning (based on social

relations, occupational functioning and use of leisure time). However, the ability of the separate axes to tap into unique and non-overlapping domains has aroused considerable debate, raising questions as to the meaningfulness of the multi-axial system. Axis V, which is comprised of the Global Assessment of Functioning Scale (GAF), has been sharply criticized for its tendency to confound symptoms and functioning (Moos et al., 2002). Indeed, studies have found that GAF ratings tend to be more closely associated with psychiatric diagnoses and symptoms than with social and occupational functioning (Skodol et al., 1988). Schrader and colleagues (1986) noted the inherent difficulty in assessing a patient's level of functioning without taking into account symptom levels and psychiatric diagnosis and the tendency for clinicians to take into account symptom levels when rating social and occupational functioning, even when instructed not to. Indeed, specific impairments in social function are often part of the criteria required for diagnosing Axis I disorders, underlining the inevitable circularity between the DSM axes.

As the above discussion highlights, analyzing and understanding data obtained from multiple assessment measures present complex challenges with no clear solutions. Despite the call for multiple assessment sources and approaches (see section 2.5), clear guidelines for dealing with them and their inherent difficulties have not yet been developed (Jacobson et al., 1999). One approach, adopted in the previous section, is to report individually the findings of each of the measures that comprise the outcome protocol. This approach provides specific information on particular areas of adaptation and dysfunction. A limitation of this approach, however, is that it can be somewhat unwieldy given the scope of the data presented. Furthermore, this approach does not offer an overall and comprehensive assessment of the subjects based on the integration of information gathered from multiple sources. A second approach is to synthesize the information gathered from multiple assessment measures into an overall functioning index. Although global scores lose information offered by multiple ratings, they have several positive characteristics relevant to outcome research. First, they allow the assimilation of knowledge regarding many different aspects of the subject's functioning – both psychiatric and psychosocial – into a clinically meaningful index of functioning. In addition, a single summary figure is particularly useful for making comparisons at multiple time intervals which is important in order to track change during treatment and at follow-up assessments. Indeed, global scores have been reported to reflect change in

therapy more sensitively than psychiatric diagnoses or symptoms (Endicott et al., 1976; McGlashan, 1973; Shaffer et al., 1983). Moreover, global scores allow for the analysis of continuous rather than dichotomous data, thus avoiding the problematic pitfall of functional-dysfunctional cut-offs that are often arbitrary and miss out on meaningful information that may not meet diagnostic criteria. They also avoid the potential implications of normal-abnormal labeling.

For the purposes of the follow-up study five measures were synthesized in order to create the AFI, an overall index of global functioning. The measures incorporated into the index include the SADS-L, SCID-II, APFA, TAPI and IOS described in section 4.2.2. It is important to stress, however, that the AFI was not designed in order to replace the important information obtained from the individual measures included in the study, but rather to augment these measures as an overall measure of global functioning. A description of the AFI follows.

5.3.2 The composition and development of the AFI

In order to integrate the five measures mentioned above into a single index, each instrument's individual rating scale had to be redefined in order to make the five scales comparable. For example, APFA ratings range from 1 to 6 whereas TAPI ratings range from 1 to 5 and IOS ratings range from 1 to 4. For each scale, a higher score reflects poorer functioning. First, all scores were converted to a scale of 0 to 100 with the highest and lowest scores of the original scales serving as anchors for the new scale and carrying the same weight for each of the different measures. So, for example, a score of 6 (highly dysfunctional) on the APFA was given equal weight to a score of 4 (very poor coping) on the IOS measure. The other intervening scores were then translated into their relative value on the new scale. After all five scales were converted to a range of 0 to 100, the new scales were inverted so that a score of 100 would reflect excellent functioning and 0 would reflect very poor functioning. In this approach, equal weight was given to each sub-scale regardless of their distribution in the current sample. Since each measure in the index was given equal weight, the six APFA sub-scales were averaged to give a single APFA score for each subject. Similarly, the three TAPI scores

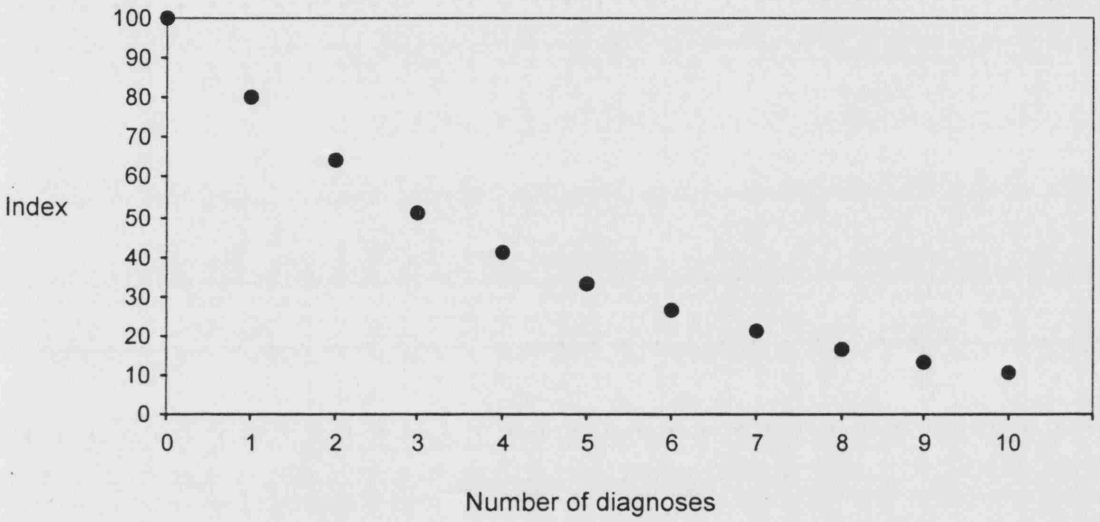
were averaged to give a single TAPI score. In the case of the IOS, an average of the four coping scores was tallied for purpose of the index. In the event that a subject did not have or could not think of a stressor in a particular domain, s/he was asked to think of another stressful event that was rated under 'Other'. In the event that a subject had less than four events to rate, the average index score took into account the overall number of domains in order to establish an average score.

For the two remaining scales, the SADS-L and the SCID-II, a different system for arriving at a final index score had to be devised. Neither measure provides an overall score or average. This makes obvious sense in clinical terms. From a psychiatric perspective, an overall score is hardly meaningful, since a clinician is interested in the particular illness or syndrome from which an individual patient is suffering. Appropriate care or treatment would be hard to determine based on a global score. However, for the purpose of the index, we wanted to create a psychopathology and a personality disorder (PD) score, based on these measures, which would reflect the extent of an individual's psychiatric functioning or dysfunction.

In the case of the SADS-L, each subject was given a number reflecting the number of past or present psychiatric diagnoses for which s/he met criteria during his or her adult life. No diagnosis in this case clearly equals 100 (best score/best functioning). A jump of twenty points was then made, with a score of 80 given to subjects with one diagnosis. This jump was made in order to give added weight to those individuals who were diagnosis-free. The underlying idea is that the difference between an individual without any psychiatric diagnosis and one with a single diagnosis is greater than that between an individual with one or two diagnoses. The issue of comorbidity is a particularly complicated one, because theoretically individuals can meet simultaneous criteria for multiple diagnoses. In the current sample, the number of psychiatric diagnoses in adulthood ranged from 0 to 8 per subject across their adult life span. Clearly, there is a certain degree of arbitrariness in converting the number of diagnoses into a scale of 0 to 100. In order to systematize the translation of the number of diagnoses to a scale of 0 to 100, taking into account the above rationale, we decided upon an exponential decreasing function of the index as a function of the number of diagnoses. In this way, we created a smaller difference between two successive numbers of diagnoses where these numbers are larger (see Figure 1). This way of indexing is in contrast to the regular linear

function. The exact exponential function f(x) that we used is based on the decision to have f(100)= 0, and f(1) = 80. The solution is the function $f(x) = 100e^{-0.223x}$. This function is presented in figure 1.

Figure 5.1. Exponential function for calculating the index number of diagnoses



Using this equation, zero diagnoses received a score of 100, one diagnosis a score of 80, two a score of 64, three a score of 51, four a score of 41, five a score of 33, six a score of 26, seven a score of 21, and eight diagnoses received a score of 17.

Regarding the SCID-II, a different approach was used in order to assign an overall PD score to each subject. Traditionally, the SCID-II is administered in two stages. In the first stage, subjects are asked to fill in a self-report screening questionnaire, using a yes/no response format. Following completion of the questionnaire, clinicians interview subjects in order to determine, through additional probing, whether the subjects' affirmative responses are actually indicative of PD symptomatology. Each diagnostic criterion (three-hundred in total) then receives a rating of "absent or false," "sub-threshold," or "threshold." A determined number of diagnostic criteria for each of the thirteen PDs need to be met in order to assign a PD diagnosis. For the purpose of the AFI personality

disorder score, we opted away from a simple count of the number of PD diagnoses assigned to each subject for several reasons. First, the current sample contained only 3 subjects who met criteria for one or more PDs. However, many of the subjects rated sub-threshold on multiple PD diagnoses. Counting only those subjects who met criteria would exclude valuable information regarding the subjects' functioning from their index score. In addition, one can argue that the severity of the various PDs varies greatly from one to the next and, therefore, a simple tally of the number of PDs does not necessarily reflect the severity of the individual's functioning (both for those who met PD criteria and for those who were sub-threshold only).

Instead, we opted to conduct a PD symptom count for each subject by tallying the number of PD diagnostic criteria that were met across the entire range of disorders. In this approach, which has been used by other researchers (see, for example, Zaider, Johnson and Cockell, 2002), subjects who met criteria for PD diagnoses, by definition, received a larger symptom count than those who did not. At the same time, it allows relevant information about subjects who did not meet criteria for a full-fledged PD, but did receive sub-threshold ratings, to be tallied for an overall PD score. The PD symptom count was then broken down into Cluster A, B and C groupings, and subjects were assigned a separate score for each of the three clusters based on the proportionate number of criteria met for all of the PDs within each cluster. Finally, subjects' total PD scores were calculated by adding up their three cluster scores. These scores, ranging form 0 to 300, were then transformed into a scale of 0 to 100, in which 0 represents the most severe level of PD dysfunction and 100 the highest PD functioning level, in keeping with the other measures included in the AFI.

As a result of the process described above, a comparable score ranging from 0 to 100 for each of the five sub-scales was obtained. For each subject, the five scores were then averaged to create an overall AFI score. As in the case of each individual score, zero represents the lowest possible level of dysfunction and 100 the highest.

5.3.3 The relationship between the five AFI sub-scales

In order to explore the relationship between the five scales that comprise the AFI, Pearson correlations were conducted. As can be seen in Table 5.11, the findings show that the APFA and SCID-II are positively correlated with all of the other measures, whereas the IOS, TAPI and SADS-L correlated significantly only with the APFA and SCID-II.

Table 5.11. Pearson correlations between the five scales comprising the Adult Functioning Index (N=33)

	APFA	IOS	TAPI	SCID-II	SADS-L
APFA	1.00	.62**	.36*	.67**	.59**
IOS		1.00	.26	.44*	.30
TAPI			1.00	.44*	.21
SCID-II				1.00	.58**
SADS-L					1.00

* $p < .05$. ** $p < .01$.

5.3.4 A reliability analysis of the AFI

A reliability analysis of the five AFI scores yielded a Cronbach alpha of 0.75. Each of the five measures contributed to the index reliability. Overall, the findings support the inclusion of these measures in the index and underscore the importance of the APFA measure.

5.3.5 Distribution of AFI scores in the current sample

Subjects received an average AFI score of 72.21, indicating a relatively high level of functioning, with scores ranging from 30.18 to 90.81. Roughly two-thirds of the subjects

(n = 22) received scores above 70, and none of the subjects received scores reflecting extremely low levels of functioning (i.e., in the 0-30 range). Six subjects received an AFI score in the 60-69 range, 4 in the 50-59 range, 1 in the 40-49 range, and 1 in the 30-39 range.

Having described the rationale, composition, development and reliability of the AFI, the remainder of this section now examines the relationship of the AFI to the adult background and outcome variables described in sections 5.1 and 5.2.

5.3.6 The relationship between AFI scores and adult background and outcome variables

a. The AFI and background variables

In order to explore the relationship between adult functioning as measured by the AFI and demographic background variables, two analyses were conducted. For continuous variables, zero-order correlations were used and for dichotomous ones t-tests were employed. Among all of the background and demographic variables, (including socio-economic level, gender, IQ scores, age at time of interview, marital status, parental status, employment status, number of children, number of partners and quality of partner relationship), three variables demonstrated a significant association with AFI scores. A t-test comparing the AFI scores of subjects involved in a long-term intimate relationship with those who were not found a significant difference between the two, $t(16) = -2.99$, $p < .01$. So too, a significant difference in AFI scores was found between subjects who were parents and those who were not, $t(18) = -2.33$, $p < .05$. Finally, Number of Children correlated with AFI scores, $r(34) = .41$, $p < .05$. In other words, subjects were who involved in a long-term, partnered relationship (whether married or cohabiting) had significantly higher AFI scores than those who were not. Since all but three of the subjects who were parents were involved in long-term cohabiting relationships, it is not surprising that parental status was also significantly associated with AFI scores. Although the results demonstrate that the greater the number of children an individual has, the higher his or her AFI score, a closer look at the data distribution indicates that this finding is of limited relevance. Of the nineteen subjects who are parents, the number

of children ranged from 1 to 4. Over half the subjects had two children, three had one child, five had three and one had four children. Given the unequal distribution, it is doubtful that this variable would be significant among a larger sample. It is interesting to note that variables such as gender, socio-economic status, and IQ levels did not correlate with AFI scores. This may be due in part to the roughly equal proportion of male and female subjects and the relatively limited distribution range for IQ and SES levels.

b. The AFI and adversity in adult life

Among the variables that assessed adversity in adulthood, Number of Severe Life Events correlated significantly with AFI scores, $r(33) = -.46$, $p < .01$. In this case, the correlation was negative, meaning that the greater the number of severe life events the subject experienced, the lower his or her AFI score. While this finding does not tell us whether adversity leads to poor functioning or vice versa, it does underscore the strong link between the two.

c. The AFI, attachment and reflective functioning

Exploring the relationship between Adult Functioning Index scores and primary AAI classification groups (F, D, E) by means of a 1-way ANOVA and Tukey between-group comparisons demonstrated significant differences among the three AAI classification groups ($p < .01$), with the secure group (F) having a significantly higher AFI score than either insecure group (D or E). Securely attached individuals (F) had an average AFI score of 84 as compared to the Insecure/Dismissive subjects (Ds) with an average AFI score of 70, and the Insecure/Preoccupied group (E), with an average AFI score of 64. The two insecure groups did not differ significantly from each other in terms of their AFI scores. Table 5.12 presents the distribution and range of AFI scores according to attachment classification.

Table 5.12. Distribution and range of AFI scores according to attachment group

Attachment group	n = 34	Mean AFI score	AFI score range
Secure (F)	13	84	71.52 - 90.81
Insecure/Dismissing (D)	9	70	48.80 - 84.58
Insecure/preoccupied (E)	12	64	82.08 - 30.18

Zero-order correlations between AFI and Reflective Functioning (RF) scores also yielded significant results. The two variables correlated significantly, $r(34) = .52$, $p < .01$. In other words, the higher subjects' RF scores, the higher their AFI scores as well.

In sum, an investigation of the relationship between adult functioning as measured by the AFI and adult demographic and outcome variables found that higher functioning AFI scores correlated significantly with being in a long-term and stable intimate relationship, being a parent, fewer severe life events, secure attachment and higher reflective capacities. Given that attachment is perceived as a potentially significant mediator of adult outcome, special attention to the relationship between security of attachment and adult functioning is explored in greater detail in the following section.

5.4 SECURE ATTACHMENT AND ADULT FUNCTIONING

5.4.1 The relationship between attachment status and the five AFI sub-scales

In order to better understand which aspects of the Adult Functioning Index correlate significantly with attachment status, the AAI classification groups were examined more specifically in terms of the five sub-scales that comprise the Adult Functioning Index. Overwhelmingly, as will be seen below, the secure group (F) demonstrated significantly better scores than the insecure groups on four of the five AFI sub-scales. In particular, the insecure/preoccupied group (E) emerged as the more troubled of the two insecure groups.

An analysis of variance comparison of the three AAI attachment groups found significant between-group differences on four of the five AFI sub-scales, with the secure group (F) receiving higher (i.e., healthier) scores. Tukey comparisons demonstrated that the significant between-group differences resulted primarily from the difference between the secure (F) group and the insecure/preoccupied group (E). The only sub-scale for which no significant differences were found pertains to the SCID-II personality disorder symptom count. Although not statistically significant, it is interesting to note that the three subjects who met full criteria for at least one PD were all classified as insecure/preoccupied (E) on the AAI.

In the case of the overall APFA score, the ANOVA demonstrated a significant between-groups difference ($p < .01$), and Tukey comparisons demonstrated that the secure group was significantly better functioning than both insecure groups (Dismissing and Preoccupied). An examination of the six APFA domains highlighted a significant difference ($p < .05$) between the secure and insecure groups particularly in relation to the domain of Intimate Relations. In this domain, the secure group displayed significantly better functioning scores than either insecure group. On the Impact of Stress (IOS) measure, secure individuals received a significantly higher overall coping score (reflecting better coping across domains) than the insecure/preoccupied group ($P < .01$). This difference appears to be accounted for specifically by significant between-group differences in the Work Domain. In this domain, Tukey comparisons demonstrated that the secure group coped significantly better than the insecure/preoccupied group ($p < .05$). Similarly, on the Transitions and Plans Interview (TAPI), the secure group demonstrated significantly better planning across domains, particularly in comparison to the insecure/preoccupied group ($p < .01$). Tukey comparisons demonstrated that the secure group achieved better scores in two domains: Education/Work ($P < .01$) and Intimate Relationships ($p < .01$). The tendency of the secure subjects to evidence better functioning was also found on the SADS-L measure that assessed the presence or absence of psychiatric illness in adulthood. Among the securely attached group, a significantly smaller percentage of subjects had met criteria for a psychiatric disorder during adulthood than in either of the insecure groups, in particular the preoccupied group. An analysis of particular psychiatric diagnoses demonstrated a significant difference between the secure and insecure attachment groups with regard to past episodes of Major Depression. Interestingly, a Chi-Square analysis revealed that none of

the securely attached subjects had suffered from a past episode of Major Depression, whereas 41% of the preoccupied and 33% of the dismissing groups had met criteria for a past diagnosis of Major Depression Disorder (MDD) during adulthood. Only three subjects met criteria for a current diagnosis of MDD; all 3 were rated insecure in terms of their attachment status.

5.4.2 The relationship between adult attachment status and personality disorder

The fact that no significant differences between attachment groups were found in relation to the SCID-II personality disorder symptom count comes as somewhat of a surprise. Intuitively, one might have expected that attachment styles or classifications would correlate with enduring problematic personality traits or characteristics. Given the somewhat controversial views regarding the DSM Axis II personality disorders (Clarkin, Kernberg & Somavia, 1998; Vaillant & McCullough, 1998) - despite its widespread use - and the fact that only three subjects met criteria for PDs based on the SCID-II, the relationship between attachment status and personality was examined from yet another perspective. As mentioned, Westen and Shedler (1999a, 1999b) devoted a great deal of research to exploring the issue of personality disorders and to developing more meaningful ways of assessing them for both clinical and research purposes. The SWAP-200, described in section 4.2.2.a.3, represents one such alternative for the assessment of personality disturbance. Recently, the authors (Shedler and Westen, in press) conducted a factor analysis of the 200 SWAP items that yielded twelve clinically relevant personality dimensions labeled as: Psychological Health, Psychopathy, Hostility, Narcissism, Emotional Dysregulation, Dysphoria, Schizoid Orientation, Obsessionality, Thought Disorder, Oedipal Conflict, Dissociated Consciousness, and Sexual Conflict. The SWAP items pertaining to each of the twelve personality factors are presented in Appendix 5.4.

To determine if attachment style differences vary along personality factors a MANOVA was conducted on the 12 SWAP-200 personality factors. The analysis revealed no significant interaction. However, a between-subject effect was found regarding the Psychological Health dimension. The securely attached group (F) differed significantly from the insecure group (D & E) on the Psychological Health dimension, $F(1,32) = 15.99$,

p. < .01, with the secure group demonstrating better scores. Pair-wise comparisons using the Bonferroni correction found specifically that the secure group demonstrated higher scores ($\bar{x}$ = 4.38, sd = .91) as compared to the insecure/preoccupied group ($\bar{x}$ = 2.96, sd = 1.06).

This difference between secure and insecure groups was also found when subjects with a primary AAI classification of 'unresolved' or 'cannot classify' were removed from the analysis, F(1,20) = 17.58, p. < .01. Tables 5.13 (n = 34) and 5.14 (n = 22) present the mean scores on the Psychological Health dimension for the secure ($\bar{x}$ = 4.43, p < .01) and insecure ($\bar{x}$ = 2.68, p. < .01) attachment groups.

Table 5.13. The mean scores on the Psychological Health dimension for the secure and insecure attachment groups

Attachment group	N	M	S.D.	F	p
Secure (F)	13	4.38	.91	15.99	.000
Insecure (D & E)	21	2.96	1.06		

Table 5.14. The mean scores on the Psychological Health dimension for secure and insecure attachment groups, excluding the unresolved and cannot classify groups

Attachment group	N	M	S.D.	F	p
Secure (F)	12	4.43	.93	17.58	.000
Insecure (D&E)	10	2.68	1.03		

In addition, MANOVAs conducted on the smaller sample ('unresolved' and 'cannot classify' subjects excluded) yielded significant differences between the secure and insecure groups in relation to three additional personality dimensions: Schizoid Orientation, F(1,20) = 4.69, p. < .05, Oedipal Conflict, F(1,20) = 6.69, p. < .05, and

Dissociated Consciousness $F(1,20) = 5.30$, $p. < .05$. Pair-wise comparisons using the Bonferroni correction found the insecure group to be more disturbed than the secure group on all three dimensions as can be seen in Table 5.15.

Table 5.15. Mean scores on the Schizoid Orientation, Oedipal Conflict, and Dissociated Consciousness dimensions for the secure and insecure attachment groups, excluding unresolved and cannot classify subjects

Personality dimension by attachment group	M	S.D.	F	P
Schizoid orientation				
Secure – F (n =12)	1.29	.84	4.69	.043
Insecure – D& E (n = 10)	2.06	.79		
Oedipal conflict				
Secure – F (n =12)	.70	.62	6.69	.018
Insecure – D& E (n = 10)	1.38	.61		
Dissociated consciousness				
Secure – F (n =12)	1.71	.96	5.30	.032
Insecure – D& E (n = 10)	2.52	.61		

The findings of this exploratory analysis lend further support to the notion that securely attached individuals differ significantly from their insecure counterparts. In particular, they highlight the relationship between secure attachment and psychological health. However, given the small size of the overall sample, the relationship between the Shedler and Westen personality dimensions and attachment classifications requires further support from larger scale studies.

5.5 DISCUSSION

5.5.1 The follow-up sample

Epidemiological evidence reported in Chapter 1 suggests that individuals who suffer from psychopathology in childhood are likely to be at risk for impairment in adulthood. One of the questions underlying the follow-up study related to the extent to which therapeutic intervention in childhood acts to forestall the negative life trajectory predicted for high-risk children. The findings from the adult outcome measures present a mixed picture, but overall seem to suggest that in adulthood, the follow-up sample is not at risk for severe adult psychopathology and poor adult functioning.

The majority of subjects reported the presence of at least one support figure, either a cohabiting partner and/or a friend, which is an important protective factor associated with decreased psychopathology and adversity (Champion, 1990; Champion & Goodall, 1993; McCarthy & Taylor, 1999; Rutter, 1990). The sample also experienced a relatively low level of adversity throughout adult life as well as relatively few severe life events during the five years preceding the interviews. In addition, the sample reported relatively good physical health and minimal use of medical services. This is in keeping with other analytic groups who reported that patients treated in psychoanalysis made fewer health insurance claims, both for psychotropic medication and for medical health services (Fonagy et al., 1999b; Leuzinger-Bohleber, 1999). Finally, the relatively low rate of personality disorders in the sample indicates that, as a whole, the follow-up group does not suffer from pervasive and chronic personality malfunctioning and its associated social, physical, and psychological impairments and costs.

Although the sample reported a somewhat higher than average rate of lifetime adult psychopathology than epidemiological studies conducted among non-clinical populations, subjects seemed to seek appropriate professional help when necessary and, in most cases, interventions tended to be brief. It is possible, then, that individuals treated with psychotherapy in childhood are able to recognize when they are in need of professional help in adulthood. As a result, they are able to 'nip problems in the bud' before they develop into full-blown psychiatric conditions that require more costly interventions. The low-risk status of the follow-up sample is further supported by the findings that, as a

group, they demonstrate adequate personality functioning across several domains (APFA findings), an ability to successfully plan and negotiate important transitions in several domains (TAPI findings), and good coping skills in some, although not all, of the domains investigated (friends and interpersonal relations, see IOS).

Finally, the distribution of attachment classifications within the sample seems to fall somewhere between clinical and low-risk samples with a lower percentage of individuals assigned a secure attachment classification than in low risk samples (Sagi et al., 1994; van IJzendoorn & Bakersman-Kranenburg, 1996), but nowhere near the low percentage of secure attachment reported in clinical samples (Dozier, Stovall, & Albus, 1999; Fonagy et al., 1996; Patrick, Hobson, Castle, Howard, & Maugan, 1994). Taken together, the findings of the adult outcome measures suggest that the follow-up sample is functioning within the normative range and does not represent a particularly vulnerable group. These findings support the view that interventions in childhood can play an important role in forestalling the negative outcomes associated with early psychopathology. Moreover, they suggest that intensive treatment in childhood can be cost-effective in the long-term. However, without a comparable control group who did not receive similar treatment in childhood, it is difficult to generalize these findings to all types of childhood therapies or to be fully confident that positive adult functioning is due to the therapeutic intervention this sample received.

5.5.2 The Adult Functioning Index (AFI)

Summarizing the findings from multiple outcome measures is a complex task. To this end, the AFI was created with the aim of augmenting the individual outcome measures included in the study. Traditionally, most outcome research has opted for either the psychiatric classification or the psychosocial assessment approach to assessment. The former tends to ignore an individual's strengths and capabilities, whereas the latter excludes mental health diagnosis. While both approaches contribute valuable information to our understanding of an individual, neither, alone, is sufficient to cover the multi-faceted range of functional and maladaptive capacities that comprise an individual's functioning. The AFI represents an attempt to integrate both approaches into an overall score that is based on a maximum amount of information. It takes into account

an individual's functioning across a broad range of domains, requiring a complex set of skills and abilities, as well as psychiatric status. Given that the follow-up study assesses individuals at a particular and somewhat arbitrary point in time, the question of whether a subject is or is not suffering from a particular psychiatric disorder at the time of the follow-up interviews is of no real consequence. Rather, it is the number of episodes and types of diagnoses that the individual has suffered from, across his or her adult life, that seem important to include in an overall measure of adult functioning. This is similar to the lifespan approach taken by the APFA, ALPHI and TAPI measures that assess aspects of functioning or adversity within a range of domains, across adult life.

A reliability analysis of the AFI demonstrated a reasonable level of internal consistency. By far, the sub-scale that contributed most to the AFI was the APFA highlighting the APFA as a particularly apt instrument for assessing overall adult functioning. This supports Hill and colleagues' (1989) intention to devise an instrument that captures the pervasive interpersonal dysfunctioning that is central to personality disorders, one that assumes that levels of functioning often vary from one domain to the next. Following the APFA, the SCID-II, which assesses personality disorders, emerged as the next most important component of the AFI. This is of particular interest given the tremendous degree of criticism that has been leveled at the entire concept of DSM personality disorders and at measures of PD in particular (see, for example, Clarkin, Kernberg & Somavia, 1998; Nathan, 1998; Westen & Shedler, 1999a, 1999b).

For purposes of the AFI, the SCID-II was not scored in terms of the type and total number of PD criteria met by subjects, as is usually the case. Instead, a symptom count of the number of individual PD criteria met within each cluster was tabulated in order to reflect an overall degree of disturbance rather than the presence of any particular personality disorder. In light of the criticism regarding the arbitrary distinctions between the various personality disorders, and the claim that important personality characteristics were excluded from multiple DSM PD diagnoses in order to enhance internal consistency (Westen & Shedler, 1999a, 1999b), the use of the SCID-II in this manner may be a more appropriate method for assessing personality functioning. It is likely that the symptom count approach, as employed in the current study, better reflects personality disturbance in general. As such, it avoids the assignment of particular diagnostic categories that are of questionable validity and thus provides a more meaningful

assessment of the degree of personality disturbance. Until such time as distinct personality disorders, as classified by the DSM Axis II, are better refined and receive more satisfactory support both conceptually and empirically, a global score arrived at by a SCID-II symptom count may offer a temporary way out of the controversy surrounding AXIS II disorders and their measurement. Rather than doing away with measures based on the DSM Axis II classification system, this approach takes into account a maximal amount of information, across a range of social skills and settings, as assessed by the SCID-II, without throwing out the proverbial baby with the bath water.

Clearly, additional studies that explore the relative merits of psychiatric diagnosis, global functioning assessment and/or a combined approach need to be conducted in order to replicate these findings. Vander Stoep and colleagues (2002), in a discussion of the relative merits of psychiatric diagnosis versus global functioning assessments, pointed out the increasing importance given to adaptive functioning within psychiatry in recent years. In their study, the authors compared a group of 181 adolescents, with and without psychiatric diagnoses, with regard to completion of secondary school and criminal involvement in young adulthood. Within this context, they looked at the predictive ability of psychiatric diagnosis as compared to the simpler methods of symptom count and global adaptive functioning. They concluded that the symptom count and global functioning assessment approaches were equally as predictive, if not superior to, the psychiatric diagnosis approach in predicting young adult outcome with regard to these two factors. Given that the latter two approaches are simpler and less time-consuming to administer than psychiatric interviews, the authors concluded that their findings are of important value to preventative programs that screen for individuals at risk for developing psychiatric disorders. Vander Stoep and colleagues (2002) qualified their conclusions, however, recognizing the important role of psychiatric diagnosis for clinical decision-making and for measuring the prevalence of psychiatric disorders. They also pointed to their small sample size as limiting firm conclusions regarding the validity of different psychiatric assessment procedures and recommended that larger scale studies be conducted.

The global score provided by the AFI is of value to both researchers and clinicians. For researchers, a single summary functioning score has multiple benefits. First, it condenses a broad range of information about an individual into a single score, enabling findings to

be presented in a more manageable way. Moreover, the index can be assessed at various time points enabling a comparison of the individual's functioning at those different times. So, for example, an individual can be assessed by the AFI before, during and after treatment. For clinicians, an assessment of functioning that is based on both psychosocial and psychiatric information offers a more comprehensive understanding of the way an individual functions. This information can, in turn, provide meaningful information about the best way in which to approach treatment, taking into account not only the disorders for which the patient meets criteria but also his or her relative strengths and weaknesses. It is important to stress that the AFI is not intended to replace psychiatric evaluations or psychosocial assessments but rather to augment individual measures that provide specific types of information. Researchers and clinicians who are interested in supplementing data based on particular measures with a single functioning score can therefore benefit from the index provided by the AFI. To conclude, the AFI represents one attempt to devise an index of functioning that takes into account both psychiatric and psychosocial perspectives. It by no means represents the only possible instrument and future research may enhance the field of outcome research through development and validation of the AFI or similar measures. Among the measures that comprise the AFI, the overall APFA score and the SCID-II symptom count contributed the most to the index. Therefore, future attempts to develop additional indices based on this model, may wish to incorporate these measures as well, or may use them as a basis for developing newer, perhaps improved instruments.

5.5.3 The relationship between security of attachment and adult adjustment

After introducing the AFI, the chapter explored the AFI in relation to several adult variables with a special focus on attachment. Given the important role of attachment as a potential mediator between psychopathology and outcome, specific attention was given to the relationship of attachment status and adult functioning. In the current sample, higher scores on the AFI were significantly related to a secure attachment status. This is in keeping with the growing body of attachment research that demonstrates a strong relationship between security of attachment and overall adaptation throughout development: within childhood, adolescence, adulthood, and even across generations (e.g., Benoit & Parker, 1994; Coble, Gantt & Mallinckrodt, 1996; Fonagy, Steele &

Steele, 1991; Roche, Rutnz & Hunter, 1999; Thompson, 1999; van IJzendoorn, 1995). Indeed, several authors have argued that security of attachment should be seen as an important resilience factor that helps a child to cope with the difficulties that life presents, without developing a psychological disturbance (Fonagy & Target, 1997; Rutter, 1995; Svanberg, 1998). As such, insecure attachment represents a vulnerability factor that hinders a child's developing competencies and ability to draw upon a range of emotional and cognitive coping skills in face of stressful life events.

Two recent studies, one conducted within a clinical sample and the other among a non-clinical sample, highlighted the relationship between secure attachment and overall psychological adjustment. Meyer and colleagues (2001) conducted a study on attachment styles and personality disorders in which 149 patients with affective, anxiety, substance use and other disorders were interviewed shortly after beginning treatment (psychotherapy, pharmacology or both) and again at follow-up 6 and 12 months later. The authors reported that a secure attachment status correlated inversely with each of the PD scales, indicating that secure attachment reflects a dimension of broad personality adjustment. Similarly, Roche and colleagues (1999) examined the mediating role of attachment between child sexual abuse and adult psychological adjustment among 307 female undergraduate students. The authors reported that although sexual abuse in childhood predicted both adult attachment style and psychological adjustment, attachment also predicted adult psychological adjustment. Moreover, when childhood sexual abuse was controlled for, attachment style continued to predict adult adjustment. However, when attachment was controlled for, sexual abuse in childhood no longer predicted adult adjustment. Based on these findings, the authors concluded that adult attachment style mediates between a history of sexual abuse in childhood and later psychological adjustment.

In the current study, secure attachment was significantly related to higher AFI scores, the latter reflecting a comprehensive assessment of psychosocial functioning. So, too, secure attachment was significantly related to Shedler and Westen's (in press) Psychological Health personality dimension. Although attachment status represents perhaps one of many mechanisms through which it is possible to understand psychological adjustment, the growing body of evidence supports the field of attachment

as a significant prism through which adult functioning can be better understood (Mallinckrodt, 2000).

5.5.4 Adult functioning and partner status through the prism of attachment

The findings of the current study underscore the strong connection between adult adjustment and partner status. Subjects who scored higher on the AFI tended to be involved in long-term cohabiting relationships and differed significantly from lower scoring individuals in this regard. Here, too, the attachment prism may help to understand these findings. Although Bowlby's (1973, 1980) theory of attachment referred to an intra-psychic process rooted in one's early relationship with primary caregivers, in the last two decades personality and social psychologists (Collins & Read, 1990; Hazan & Shaver, 1987) have applied attachment related concepts to the area of adult love relationships (Bifulco, Moran, Ball & Bernazzani, 2002a; Bifulco, Moran, Ball & Lillie, 2002b; Stein, Koontz, Fonagy & Allen, 2002). They posit that childhood relationships with parents impact on adult romantic relationships and they draw a parallel between child-parent and adult romantic attachment. Hazan and Shaver (1987, 1994; Shaver & Hazan, 1993) reported that security of attachment is associated with a desire for intimate relationships and the ability to feel comfortable with a feeling of dependency and a need for closeness. Accordingly, secure adults seek out romantic relationships in which autonomy and intimacy are balanced. In contrast, insecurely attached adults display a different attitude toward intimate relationships. Insecure individuals with an anxious/ambivalent attachment style desire closeness, but their fear of rejection leads them to seek out lower levels of autonomy and more extreme forms of intimacy. Insecure individuals characterized by an avoidant attachment style, on the other hand, are uncomfortable with feelings of dependency and intimacy and, as a result, need to maintain distance and independence.

In the current study, securely attached individuals demonstrated better functioning scores in the domain of intimate relationships on two separate measures - the APFA and the TAPI. In other words, securely attached subjects were characterized by intimate relationships based on mutual trust, confiding and support throughout their adult life. Moreover, they displayed the ability to actively plan and negotiate their romantic

involvements rather than respond passively to others in this domain. These findings are in keeping with a study by McCarthy (1999) who examined the relationship between attachment style and love relationships among 40 women known to be at risk for relationship problems. As in the current study, his sample demonstrated that securely attached individuals displayed significantly better functioning in the APFA love domain. It is important to point out, however, that whereas McCarthy assessed attachment by means of the Hazan & Shaver Adult Attachment Questionnaire (1987), in the current study attachment classifications were assigned on the basis of the Adult Attachment Interview. It is therefore worthwhile that future studies attempt to replicate these findings using the AAI, preferably among a larger sample size. McCarthy also found that difficulties in adult love relationships were particularly related to an avoidant attachment style. In the current study, no significant differences between the two insecure groups (dismissing and preoccupied) emerged; both groups displayed significantly poorer functioning in the APFA love domain than the secure group, but did not differ significantly from each other. On the TAPI measure, however, it was the preoccupied insecure group that displayed significantly poorer functioning than the secure group in regard to intimate relationships. Since both the current study and that reported by McCarthy involved small sample sizes, the ability to generalize about distinctions between the two insecure sub-groups (preoccupied and dismissing) is limited. Notwithstanding, the evidence from both studies lends support to the relationship between secure attachment and the ability to form healthy intimate relationships in adulthood.

Over the past few decades a growing body of research has pointed to the protective role of marital or long-term cohabiting relationships (see for example, Brown & Harris, 1978; Campell et al., 1983; Rutter, 1990). Research findings have emphasized the importance of a positive marital relationship, one based on emotional intimacy, which serves as a buffer against vulnerability, whereas partners with a history of drug or alcohol problems are linked to low levels of support and marital breakdown (Quinton et al., 1984; Rutter & Quinton, 1984). The long-term effect of poor marital relations is of significance not only to the adult couple involved, but also to their offspring. Indeed, research has demonstrated that marital discord and lack of support, along with other marital difficulties, are strongly linked with the development of psychological disorders in both childhood (Farrington, 1995; Jouriles et al., 1988; Patterson, 1982) and adulthood

(Brown & Harris, 1978; Quinton & Rutter, 1988; Sampson & Laub, 1993). Interestingly, attachment research supports the notion that adult attachment style plays an important role in the process of partner selection (Belsky & Cassidy, 1994; Hazan & Shaver, 1994) and the subsequent quality of the relationship (Collins & Reed, 1990; Davis et al., 1994; McCarthy & Taylor, 1999; Mikulincer & Nachshon, 1991; Simpson et al., 1992). These studies have demonstrated that securely attached individuals tend to seek out partners with whom they are able to establish a satisfying relationship, characterized by commitment, love and trust.

A series of studies conducted by Brown and colleagues underscored the link between negative experiences in childhood leading to poor self-esteem and negative intimate relationships in adulthood, often associated with a vulnerability to depression (Andrew & Brown, 1988; Brown, Bifulco & Andrews, 1990; Brown et al., 1990; Brown & Moran, 1994). McCarthy and Taylor (1999) reported a similar link between abusive experiences in childhood and later difficulties in creating supportive cohabiting relationships and the selection of deviant partners. The authors suggest that attachment style serves as a primary mediating factor underlining these processes. Based on their findings, McCarthy and Taylor (1999) concluded that the link between adversity in childhood (in the form of sexual abuse) and poor adult cohabiting relationships are mediated by an insecure attachment style, particularly an avoidant/ambivalent one. The authors cautioned, however, that in addition to attachment style additional factors may serve as mediating factors, including cognitive-affective variables such as emotional regulation, bodily shame, and genetic and temperamental factors. They also pointed out that while attachment style seems to impact on the quality of close adult relationships, it is also possible that individuals who experienced negative close relationships may develop an insecure attachment style. Both in the McCarthy and Taylor study (1999), and in the current one, attachment as a potential mediator was assessed concurrently with measures of adult functioning in the love domain; attachment was not assessed in childhood. Clearly, there is an urgent need for longitudinal prospective studies in which attachment styles are assessed prior to the development of intimate adult relationships. Studies of this kind should allow a more powerful test of the long-term mediating potential of early attachment style on the ability to create and maintain positive intimate relationships in adulthood.

5.5.5 The relationship between life events, adult functioning, and attachment

An increasing body of evidence demonstrates that individuals who suffer from psychiatric disorders in childhood are more likely to create disadvantageous social environments and unsupportive or poor relationship patterns later in life, two factors associated with stressful life events (Champion et al., 1995; Rutter, 1990, 1997; Rutter & Quinton, 1984). In the current study, despite a disordered childhood, the follow-up sample reported a relatively low number of severe life events or adversity. Indeed, the study found a negative correlation between the number of severe life events subjects experienced in the previous five years and their AFI scores. Thus, individuals with higher levels of adult functioning tended to have experienced significantly fewer severe life events than those individuals with poorer adult functioning scores. How are we to understand these findings? Is this mere coincidence or is there something about well-functioning individuals that actually prevents adversity and, if so, what factors play a role in this process? One of the components of the AFI is an assessment of an individual's coping skills cross a range of domains. In the current sample, the overall coping skills of securely attached individuals were rated as significantly better than those of their insecure counterparts. It is possible, then, that better coping skills prevent minor adversities from developing into severe ones and, perhaps, even prevent certain severe life events from developing in the first place. However, highly developed coping skills cannot prevent the complete range of severe life events. It is important to stress that life events in the current study were assessed according to an objective contextual measure of adversity and not on the basis of the subjects' subjective assessment of the degree of severity. A second possible explanation (which does not negate the previous explanation and may exist alongside it), relates to the role of attachment as a mediator in this process. In the current sample, security of attachment was significantly linked to higher AFI scores; as such, it may have played a mediating role in limiting the extent of adversity in the lives of this group of individuals. Since security of attachment was positively associated with overall adult functioning across several measures and domains, it may be that secure attachment represents a resilience factor that mitigates the degree and extent of adversity and enhances the individual's ability to cope more effectively when faced with adverse life events (Fonagy & Target, 1997; Svanberg, 1998).

Some initial support for this viewpoint is provided by a study conducted by Waters and colleagues (2000) in which 12 month-old infants classified by the Strange Situation were followed up 20 years later and assessed by the AAI. The authors reported that when subjects who had experienced severe life events were removed from the sample, there was a 78% correspondence between secure and insecure attachment in infancy and adulthood. Moreover, negative life events were significantly associated with a change from secure to insecure attachment status.

In keeping with this perspective, it is perhaps possible to view security of attachment as a buffer against adversity in general. Svanberg (1998), in his discussion of attachment and adverse life events, drew a bridge between the mother's ability to remain secure despite severe stressful events and the ability to break the inter-generational transmission of insecurity from one generation to the next. He cited a recent study by Phelps and colleagues (1998) in which two groups of mothers were assessed by the AAI. They found that mothers who were able to describe their past in a coherent and balanced way, despite a difficult or traumatic childhood, were better able to maintain positive parenting during highly stressful periods than insecurely attached mothers. These findings lend further support to the view of secure attachment as a buffer against adversity, a mediator that enables individuals (and their children) to emerge relatively unscathed despite the odds against them. Svanberg (1998) concluded that insecure attachment represents a psychosocial disability, particularly in the face of stressful or traumatic experiences, and suggested that this weakness underlies the phenomenon of the "walking wounded of most mental health services, as well as a fair proportion of the incarcerated population" (p. 552). The interplay between attachment status, adult functioning and adversity is illustrated by Ms. J. whose case history follows.

The interplay between severe life events and adult functioning: A case study

The case of Ms. J. (ID no. 285) illustrates the way in which severe life events can exacerbate adult functioning and their relation to psychopathology and insecure attachment status. Ms. J. represents an example of a patient who despite impressive treatment gains (referral HCAM 58, termination HCAM 90) was apparently unable to sustain the benefits of treatment in the long-term as reflected in her Adult Functioning Index score of 64. In adulthood, Ms. J. has suffered continuously from both physical and psychological disturbances of a severe nature. Perhaps most striking is her multiple and

highly problematic intimate relationships and the seemingly connected and relatively high number of severe life events that typify her adult life. In attachment terms, Ms. J. was classified as 'cannot classify/preoccupied'. Both in her case file notes and in her adult interviews described below, one senses that her primary attachment relationships were highly conflictual, remaining unresolved even at the end of a lengthy bi-weekly treatment process (approximately 4 3/4 years in length), perhaps leading to poor partner choice that, in turn, led to increased stressors and crises. The complex interplay of physical and psychological difficulties is a running theme throughout her life history. It is suggested that Ms. J.'s insecure attachment status was unaltered by treatment in childhood, despite its short-term benefits, and that this insecure status resulted in the selection of abusive and inappropriate intimate partners, leading to an adult history replete with severe life events.

Ms. J. was given up for adoption by her biological mother and handed over to her adoptive parents at the age of six weeks directly from the hospital where she was born six weeks prematurely. Her case file has minimal details regarding her early development, but Ms. J. was described by her adoptive parents as an easy baby who did not present any particular difficulties during early childhood. According to Ms. J.'s adoptive parents, difficulties began when she started attending school. Mornings were characterized daily by tears and fussiness over some minor item of one kind or another alongside frequent somatic complaints. By age twelve, Ms. J.'s parents felt they could no longer handle her and consulted with the adoption agency that had placed her with them. The agency worker recommended that they seek professional help and Ms. J. seemed eager to talk to someone about her problems. Interestingly, the general secretary of the adoption agency reported that relative to other adoptions arranged by the agency, the adoption of Ms. J. seemed "to be one of our disasters". Following the death of her rabbit and watching Jane Eyre on television, Ms. J. developed nighttime terrors and following a bout of the flu refused to return to school. At this time, Ms. J. developed multiple claustrophobic symptoms and a number of hypochondriacal fears. Alongside these fears, Ms. J. was frequently in tears, and often abusive and aggressive towards her parents and younger brother (also adopted). As for her parents, neither described or displayed signs of psychopathology. Although father was perceived as warmer toward Ms. J. than mother, the latter appeared to be the more dominant parent with her father

playing a fairly passive role. No information regarding her biological parents' mental health was present in her case file.

The therapist who interviewed Ms. J. commented on her ambivalent dependence on her mother and regressive clinging to her. She seemed to be suffering from neurotic type conflicts in a pre-adolescent stage and presented with depression, low self-esteem, bodily anxieties and phobic disturbance. The therapist was concerned that without treatment, adolescence would likely exacerbate these disturbances, leading to increased conflicts with her parents, with possible extensions to the wider adult world. So, too, the therapist raised concerns about Ms. J. engaging in desperate acting out attempts to cope with her severe depression and strict superego. Although intensive psychoanalysis was recommended, due to logistical circumstances twice-weekly treatment was offered. Ms. J. received treatment for nearly five years and her parents participated initially in parent guidance as well, although this tapered off. Treatment was terminated by mutual consent with the analyst. Ms. J. and parents agreed that treatment had been highly beneficial and was no longer necessary. According to her case notes, in her last session, Ms. J. spoke glowingly of improvement in many areas, including: success at school, a new relationship with a boyfriend which gave her much pleasure, enjoyment from guitar playing and activities connected to it, lack of depression, and improved relationship with her parents who seemed to her to have developed a sense of humor and an ability to deal with her rationally and with trust. Ms. J. expressed the feeling that her luck had changed and the fear and uncertainty that it was "too good to be true".

Ms. J. was approximately sixteen and-a-half years of age when she completed treatment. Within the year she left home due to its oppressive and argumentative atmosphere. At this stage, Ms. J. had been working and paying her keep. Following her father's decision to impose a curfew on her and the ensuing arguments regarding her violation of the curfew, Ms. J. decided to leave home and move in with her boyfriend. She never returned home. She married her boyfriend at age 18 and gave birth to her son about two years later. Her husband turned out to be a homosexual and Ms. J and he divorced when she was twenty-two years old. Soon after, Ms. J. began a romantic relationship with a family friend and after four to five months she moved in with him. They soon married, but due to sexual problems in the relationship they were divorced when Ms. J. was twenty-four years old. Before the divorce came through, Ms. J. had already met her third

husband-to-be whom she dated for a year and then moved into his home. He turned out to be extremely violent and abusive and their marriage was legally terminated when Ms. J. was thirty years old, although they had been separated before that time. Before and after the divorce, this ex-partner harassed Ms. J., being violent to her and threatening to her son repeatedly. Ms. J. met her current husband through their joint membership in Jehovah's Witnesses. They were friends for quite some time before deciding to wed and although they both suffer from recurring depression (and her husband also suffers from severe sexual dysfunction), Ms. J. is very satisfied with her relationship, finds him to be her best friend, and describes it as a mutually supportive and non-abusive relationship. Following her most recent marriage, Ms. J.'s son began exhibiting severe behavioral problems at school, in the community and towards his mother, including extreme violence (apparently conduct disorder). The violence reached such high levels that social services eventually recommended he be placed with a foster family.

Alongside these acute difficulties, Ms. J. suffers from a Lupus-like disorder called anti-phospholipid syndrome that began after the birth of her son. It is an incurable illness that causes extreme headaches and fatigue along with depression and panic attacks. At the time of the follow-up interviews, Ms. J. was housebound, extremely limited in what she could do physically (mostly computer related activities such as correspondence, budgeting, bill paying), and almost completely dependent on her husband and friends. She also met criteria for 3 psychiatric disorders (both past and present), including panic disorder, phobic disorder, and MDD. The presence of these disorders, alongside her extreme interpersonal difficulties resulted in a relatively low adult functioning score (AFI = 64), despite adequate coping skills and functioning in several domains and the lack of a DSM Axis II personality disorder.

Despite the upbeat and optimistic sense that pervaded the end of Ms. J.'s treatment, it appears that her premonition that "it was too good to be true" was accurate. While treatment had clearly removed many of the overt symptoms that brought her to treatment, it appears that the highly conflictual and even abusive nature of her early attachment relationships continued to haunt her or, perhaps more accurately, Ms. J. continued to seek out relationships that vacillated between passive rejection and withdrawal to overt aggression and abuse. Having made the choices she did with regard to intimate partners, it would seem that Ms. J. put out the 'welcome mat' for a series of severe crises and life

events. Although her medical history has also caused no small number of crises, her physical and mental states seem highly intertwined such that at least some part of her medical crises may also be related to her apparently insecure attachment status.

Ms. J.'s adult history and functioning is atypical of many of the follow-up subjects who, despite a propensity toward adult adversity due to early psychopathology, appear to have overcome their negative odds, leading a relatively stress-free and functional adult life. Evidence from the current study's findings seems to suggest a connection between positive adult functioning, security of attachment and fewer severe life events. However, further studies are clearly needed in order to clarify the complex relationship between functioning, adversity and attachment, and to better understand the processes underlying this relationship.

5.5.6 AFI, attachment and psychopathology

Another area that has received increasing attention in recent years concerns the relationship between attachment status and psychopathology, both among clinical and non-clinical populations. Overwhelmingly, research has shown insecure attachment to be an important risk factor for the development of psychiatric disorder throughout the life span: in childhood (Lewis, Feiring, McGuffog & Jaskir, 1984; Sroufe & Egeland, 1989), adolescence (Cole-Detke & Kobak, 1996; Rosenstein & Horowitz, 1996) and adulthood (Cyranowski, 2002; Mickelson, Kessler & Shaver, 1997; Strauss, 2000; van IJzendoorn & Bakermans-Kranenburg, 1996). Less is known, however, about a possible relationship between the different attachment styles and particular forms of psychopathology. Dozier and colleagues (1999), in their summary of this relationship, concluded that attachment styles do not differentiate clearly between different diagnostic categories, although they did find a high prevalence of insecure preoccupied attachment styles in most clinical subgroups. Similarly, Fonagy and colleagues (1996), in a comparison of non-psychotic inpatients with case-matched controls, found that psychiatric patients were more likely to be classified as insecurely preoccupied or unresolved with respect to loss or abuse. In addition, they reported that anxiety disorders were associated with an unresolved attachment status.

The findings of the current study lend further support to the connection between insecure attachment and psychopathology in general. In the follow-up study, individuals who were classified as securely attached (F) met criteria for a significantly lower percentage of psychiatric disorders in adulthood than did either the preoccupied or dismissing insecurely attached subjects. In particular, this difference was greatest between the secure and preoccupied groups. Interestingly, in a 3-way analysis (F, D and E), a past diagnosis of Major Depressive Disorder (MDD) stood out as significantly distinguishing among the attachment groups. None of the securely attached subjects had met criteria for either a past or current episode of MDD. In contrast, chi-square analyses revealed that 62% of the preoccupied (E) and 38% of the dismissing (D) insecurely attached groups had experienced MDD in the past.

Several researchers have reported a specific connection between depression and insecure attachment, both among clinically depressed individuals (Fonagy et al., 1996; Mickelson, Kessler & Shaver, 1996; Patrick, Hobson, Castle, Howard & Maughan, 1994; Pettem, West, Mahoney & Keller, 1993) and among non-clinical samples (Carnelley, Petromonaco & Jaffe, 1994; Murphy & Bates, 1997; West et al., 1998). The particular link between depression and a preoccupied attachment classification as found in the current study, however, requires further exploration and validation. The results of two studies, both conducted among adolescent populations, lend support to the association linking depression with the preoccupied attachment style. Rosenstein and Horowitz (1996), for example, looked at the relationship between attachment classification, psychopathology and personality traits among a sample of 60 hospitalized adolescents. They found that adolescents classified as preoccupied were more likely to have an affective disorder. In contrast, dismissing individuals were more likely to suffer from conduct or substance abuse disorder. These findings are in keeping with the association between preoccupied attachment and affective disorders reported by Cole-Detke and Kobak (1996), also among an adolescent population.

Cyranowski and colleagues (2002) examined the relationship between attachment status and depression from a somewhat different angle. In their study, the authors examined the attachment profiles, interpersonal difficulties and treatment responses in 162 women receiving interpersonal psychotherapy (IPT) for recurrent major depression. Although attachment style did not distinguish between patients who did or did not remit as a result

of IPT, the authors reported a positive association between high Fearful Avoidant attachment ratings and a longer time to clinical stabilization. Here, too, it is important to note that attachment styles were classified based on Bartholomew and Horowitz's Relationship Questionnaire (Bartholomew, 1990; Bartholomew & Horowitz, 1991) and not on the AAI. A somewhat different picture regarding the relationship between depression and insecure attachment emerged from a study conducted by Fonagy and colleagues (1996). In their study, attachment as assessed by the AAI was used to predict the rate of improvement between admission and discharge among a group of 82 non-psychotic patients. In contrast to the findings reported above, the authors found that patients suffering from major depressive disorder (MDD) were significantly more likely to be securely attached as compared to either bipolar or dysthymic patients. The authors explained this finding in terms of the nature of MDD, which unlike bipolar or dysthymic disorders, tends to be episodic and thus less disruptive to the personality, thereby enabling a secure attachment status. Clearly, the complex interplay between insecure and secure attachment styles and particular forms of psychiatric disorder requires additional study in order to tease out the potentially multiple relationships between these factors.

Distinctions between the dismissing and preoccupied insecure attachment groups have been reported, but not necessarily in relation to affective disorders. Pianta, Egeland and Adam (1996) reported that dismissing subjects reported fewer symptoms and least anxiety as compared to preoccupied subjects, with the latter group exhibiting the highest degree of distress and problems in relationships. In contrast, Stein and colleagues (2002) found that dismissing subjects actually experience a relatively high level of symptoms, however these tend not to be related to the domain of interpersonal relationships. Based on their findings, they concluded that while the dismissing attachment status may represent a successful defense against interpersonal anxiety, it does not seem to successfully defend against other types of symptoms and difficulties. Thus, although it appears that insecure attachment patterns are more common in clinical populations, it remains questionable whether particular types of insecure attachment styles can predict specific types of psychiatric diagnoses or even major diagnostic groupings (i.e., anxiety, affective or behavioral disorders). The findings of the current study suggest a possible distinction between the two types of insecure attachment style - preoccupied and dismissing - with specific regard to depression. However, given the small sample size,

additional controlled studies based on larger samples are needed to determine whether particular Axis I and II disorders, as assessed by standardized measures, are indeed related to particular types of attachment classifications (Fonagy et al., 1996).

5.6 CONCLUSIONS

This chapter focuses on the adult demographic and outcome data of the AFC follow-up sample. Based on the outcome data, the follow-up sample appears to be a relatively well-functioning group, despite their high-risk childhood status. The findings cautiously suggest that intensive psycho-dynamically oriented treatment in childhood may have helped to forestall many of the negative trajectories associated with early psychopathology. The chapter then introduces the Adult Functioning Index (AFI), a scale designed to provide an overall global functioning score including both symptomatology and adjustment across a broad range of domains. A reliability analysis of the AFI demonstrates a reasonable level of consistency, and the AFI correlates significantly with partner status, lower adversity, security of attachment, and higher levels of reflective functioning. Special attention is given to the role of secure attachment as a mediator affecting adult outcome. In particular, the findings underscore the relationship between adult functioning and secure attachment with regard to psychopathology, life events and intimate relations. As such, they highlight the protective role of secure attachment and mutually supportive relationships on long-term adult functioning. The relationship between adult outcome and specific childhood variables is explored in the next chapter.

CHAPTER 6. CHILDHOOD PREDICTORS OF ADULT OUTCOME

The current chapter explores the relationship between childhood factors assessed retrospectively through the subjects' childhood case files and their current adult functioning. First, the chapter analyzes a range of childhood variables taken from the retrospective study (see section 3.3) and their relationship to adult adaptation as measured by the Adult Functioning Index (AFI) presented in Chapter 5. Specifically, the chapter looks at correlations between childhood variables and AFI scores and, through the use of regression analysis, examines those variables that appear to be the most powerful predictors of long-term adult functioning following psychoanalytic treatment in childhood. The analysis focuses on childhood variables taken from two distinct points in time – assessment (pre-treatment) and termination (conclusion of treatment) – in an attempt to understand which child characteristics best predict adult outcome and the role of therapeutic intervention in this process. Clinical vignettes illustrating the pathways from poor childhood functioning to both adaptive and maladaptive adult functioning are presented. Special attention is given to the role of secure attachment as a mediating variable, and childhood variables predictive of secure and insecure adult attachment are explored. In addition, childhood determinants of adult adversity are examined in light of the relationship between emotional and behavioral problems in childhood and severe life events in adulthood (Champion et al., 1995). Finally, the protective role of child psychoanalysis as a moderator of the deleterious effects of childhood disorders on long-term adult outcome is discussed.

6.1 THE RELATIONSHIP BETWEEN CHILDHOOD VARIABLES AND ADULT OUTCOME (AFI)

The relationship between childhood variables and adult outcome is explored through both correlation and regression analyses. Childhood variables are taken from two separate points in time: assessment (pre-treatment) and termination (conclusion of treatment). They are divided into five categories, including: *demographic and family variables* (family socio-economic level, father's country of origin, mother's country of

origin, father's religion, and mother's religion); *parents' mental health and global functioning* (mother's past DSM diagnosis, mother's DSM diagnosis at assessment, mother's GAF score, father's past DSM diagnosis, father's DSM diagnosis at assessment, father's GAF score, mother's psychiatric history at assessment, mother's past psychiatric history, father's psychiatric history at assessment, father's past psychiatric history, presence of parental DSM diagnosis - past or present); *child and clinical variables* (gender, age at start of treatment, patient past DSM diagnosis, patient assessment HCAM score, number of referral diagnoses, number of learning difficulties, IQ score); *treatment variables* (session frequency, length of treatment, parent guidance during treatment, primary reason for termination); *termination variables* (presence of DSM diagnosis at termination, number of termination diagnoses, termination HCAM score, HCAM change score, subsequent treatment). The full list of the 32 childhood variables and their labels are presented in Appendix 6.1.

6.1.1 Estimating missing values

Before embarking on correlation and regression analyses, it was necessary to deal with the problem of missing data. Although the childhood records at the Anna Freud Centre provide a very rich and expansive source of information regarding children who received treatment at the Centre, the file data by nature is uneven. First, many different analysts, representing a spectrum of clinical experience (ranging from trainees to senior analysts) authored the case notes which form the basis for the variables under investigation. This lack of homogeneity is further complicated by the fact that the analysts who recorded information in the files had no knowledge of the research variables relevant to future studies. As a result, many of the variables examined by the retrospective and the follow-up study could not be estimated for some of the subjects. In the current study, this lack of data is particularly problematic given its small sample size. In order to contend with the problem of missing data, the SPSS missing value estimation procedure was utilized. Once missing values were estimated, correlation and regression analyses were carried out. Appendix 6.2 presents a correlation matrix of all the childhood variables and the AFI.

A comparison of correlation analyses with and without the inclusion of estimated missing variables highlighted an identical list of childhood variables that correlate significantly with AFI scores, with the exception of three variables. The first variable relates to whether or not father met criteria for a DSM diagnosis at assessment (with values, 1 or 0). This variable was found to be significant when estimated variables were not included, $r(25) = .52$, $p = .008$; it was not found to be significant when estimated variables were included, $r(34) = .20$, $p = .250$. The second variable relates to the change in HCAM score from assessment to termination. Here, too, a significant correlation was found only when estimated values were not included, $r(27) = .42$, $p = .030$. A third, less significant discrepancy relates to a dichotomous variable that assesses the presence or absence of a DSM termination diagnosis. When estimated variables are included, this variable correlates significantly with AFI scores, $r(34) = .41$, $p = .016$. In contrast, when estimated missing values are not included, the correlation is not significant, $r(21) = .41$, $p = .067$. It is likely, however, that this minor difference in significance levels is due to the small sample size (n=21) in the second analysis and that the significant correlation found with a larger sample size better reflects the direction of the findings.

A comparison of multiple regression analyses found that the same childhood variables, both with and without estimating missing values, predict AFI scores at similar levels of significance. A marginal difference in significance levels did occur in reference to a regression analysis of the six child and clinical variables. When missing values were not estimated, Patient HCAM emerged as the most significant predictor of AFI at $p < .05$. In contrast, when estimated variables were included in the regression analysis, Patient HCAM was just outside the significance level ($p = .059$). Given the almost non-existent discrepancies between both sets of correlation and regression analyses (with and without estimated missing values), all further findings will be based on data including estimated missing values. Only childhood variables found to correlate significantly with AFI scores at a level of $p < .05$ or less are described below. The results of correlation and regression analyses are presented in Table 6.1.

Table 6.1. Correlation and regression analyses for childhood variables and AFI, within categories and between categories

Variable	Correlation	R-Square	Beta
I. Child & Clinical:			
a. Gender	.285		
b. Age at treatment	-.100		
c. Past DSM diagnosis	.274	.222**	.471**
d. HCAM score	.471**		
e. No. referral diagnoses	-.356		
f. No. learning difficulties	-.287		
g. IQ score	.361		
II. Parent Mental Health/Functioning:			
a. M DSM diagnosis/past	.221		
b. M DSM diagnosis/assessment	.267		
c. F DSM diagnosis/past	.250		
d. F DSM diagnosis/assessment	.203		
e. M psychiatric history/past	-.033		
f. M psychiatric history/assessment	-.074		
g. F psychiatric history/past	.044		
h. F psychiatric history/assessment	-.273		
i. M/F psychiatric diagnosis/assessment	-.331		
j. M GAF score	-.396*		
k. F GAF score	-.384*		
III. Treatment Variables:			
a. Session frequency	.167		
b. Length of treatment (in years)	.040		
c. Primary reason for termination			
d. Parent guidance during treatment	-.022		
IV. Termination Variables:			
a. Termination DSM diagnosis	.411*		
b. Termination HCAM score	.420*	.217**	-.466**
c. HCAM change score	.155		
d. No. termination diagnoses	-.466**		
e. Subsequent treatment	.021		
V. Mother (M) Variables:			
a. M GAF score	.396*		
b. M DSM diagnosis/past	.221	.157*	.396*
c. M DSM diagnosis/assessment	.267		
d. M psychiatric history/past	-.033		
e. M psychiatric history/assessment	-.074		

* significant at the $p < .05$ level.
** significant at the $p < .01$ level.

Table 6.1 Continued

Variable	Correlation	R-Square	Beta
VI. Father (F) Variables:			
a. F GAF score	.384*	.147*	.384*
b. F DSM diagnosis/past	.250		
c. F DSM diagnosis/assessment	.203		
d. F psychiatric history/past	.044		
e. F psychiatric history/assessment	-.273		
VII. Mother vs. Father GAF Score:		.209*	.396*
a. Mother GAF score	.396*		
b. Father GAF score	.384*		
VIII. Child vs. Parent Functioning:		.222**	.471**
a. Child HCAM score	.471**		
b. Mother GAF score	.396*		
c. Father GAF score	.384*		
IX. Child & Clinical vs. Termination Variables:		.222**	.471**
a. Child HCAM score	.471**		
X. Before and After HCAM scores		.222*	.471**
a. Child HCAM score	.471**		
XI. Before and After Diagnoses:			
a. No. of termination diagnoses	-.466**	.217**	-.466**
XII. Child & Clinical vs. Treatment Variables:			
a. Child HCAM score	.471**	.222**	.471**
XIII. Termination vs. Treatment Variables:			
a. No. of termination diagnoses	-.466**	.217**	-.466**

* significant at the $p < .05$ level.
** significant at the $p < .01$ level.

6.1.2 Assessment variables

a. Zero-order correlation analysis

Several of the continuous assessment variables correlated positively with AFI scores. These included: Patient's HCAM score, Mother's GAF score, Father's GAF score, and Average IQ score. In addition, the Number of Referral Diagnoses in childhood correlated negatively with adult outcome or, in other words, fewer referral diagnoses at onset of treatment in childhood correlated with higher AFI scores. A final dichotomous variable, relating to the presence or absence of one or more psychiatric diagnoses among either parent at assessment, came close to significance. This variable correlated negatively with the AFI at a nearly significant level ($p = .055$). A t-test comparing the nineteen subjects whose parents had a diagnosis at referral with the fifteen who did not yielded a similar level of significance in the separate variance estimate, $t(31) = 2.09$, $p = .045$. In other words, the presence of psychiatric disorders in one or both parents at assessment correlated with lower AFI scores in adulthood at a nearly significant level.

b. Regression analysis

In order to determine whether childhood variables predicted AFI scores, stepwise multiple regressions were conducted.

1. Child & Clinical Variables at Assessment. Using a forced entry of all of the Child & Clinical variables (including: Gender, Age at Start of Treatment, Previous DSM Diagnosis, Patient HCAM Score, Number of Referral Diagnoses, Number of Learning Difficulties, and IQ level), a step-wise multiple regression indicated that Patient HCAM Score accounted for the largest amount of the AFI score variance (22.2%), $\beta = .471$, $p < .01$. In order to achieve a fuller understanding of the relative role of the various Child & Clinical variables, a backward regression analysis was conducted. Its result showed that three of the variables contribute to the AFI variance (explaining 34%), including Patient HCAM, the Number of Referral Diagnoses and IQ level. In contrast, Age at Start of Treatment, a Previous DSM Diagnosis, and the Number of Learning Difficulties contributed little or nothing. In other words, although the child's global functioning level

at assessment best predicted adult outcome, higher IQ levels and a smaller number of referral diagnoses also contributed to long-term adult functioning.

2. Parent Mental Health and Global Functioning. A stepwise regression exploring a range of variables pertaining to the mental health status of the subjects' parents (measured by DSM diagnoses, GAF - global functioning scores, and general presence of a psychiatric history, even if not fully diagnosable in DSM terms) did not yield significant results.

A regression using only the variables pertaining to Mother (including: Mother Past DSM Diagnosis, Mother DSM Diagnosis at Assessment, Mother GAF Score, Mother Psychiatric History at Assessment, and Mother Past Psychiatric History), highlighted Mother GAF score as the single significant predictor of AFI scores, explaining 15.7% of the AFI score variance, $\beta = .396$, $p < .05$. Similarly, a stepwise regression of variables related only to Father's mental health (including: Father Past DSM Diagnosis, Father DSM Diagnosis at Assessment, Father GAF Score, Father Psychiatric History at Assessment, Father Past Psychiatric History) underscored Father GAF score as the only significant predictor of adult functioning, explaining 14.7% of the AFI score variance, $\beta = .444$, $p < .05$. Interestingly, when Mother and Father GAF scores were entered together into the regression, only maternal GAF emerged as a significant predictor of adult outcome (explaining 15.7% of the variance). Separate analyses of DSM diagnoses and general psychiatric history did not yield significant results.

3. Child versus Parent Psychiatric Functioning. A second regression explored the relative predictive power of child versus parent (mother and father separately) global functioning scores. This regression explained 2.2% of the variance in AFI scores, $\beta = .471$, $p < .01$. Specifically, when Patient HCAM, Mother GAF and Father GAF scores were entered into the regression, Patient HCAM emerged as the more powerful variable. Although this represents a rather small proportion of the total variance, it is of interest to note that it was the child's global level of functioning and not his or her parents' level of functioning that better predicted adult outcome. A similar outcome emerged when the Number of Referral Diagnoses was compared with the Presence of DSM Diagnoses in Mother or Father at Assessment. In this analysis, only the child

variable (Number of Referral Diagnoses) predicted AFI scores in a significant manner, $\beta = .356$, $p < .01$. 12.7% of the variance was explained by the child variable pertaining to DSM diagnoses as compared to 2.2% of the variance explained by the child's global functioning scores (HCAM).

6.1.3 Termination variables

a. Zero-order correlation analysis

Several variables pertaining to the termination time period correlated significantly with AFI scores (see Table 6.1). Two continuous variables correlated significantly with adult outcome: Subjects' Termination HCAM score and the Number of Termination Diagnoses. In the latter case, a negative correlation was found indicating that the greater the number of termination diagnoses at end of childhood treatment, the lower the long-term functioning score achieved in adulthood. In keeping with this finding, an additional dichotomous variable assessing the overall presence or absence of a DSM Diagnosis at Termination also correlated significantly with AFI scores.

b. Regression analysis

Using a forced entry of the five Termination Variables (including: Presence of DSM Diagnosis at Termination, Number of Termination Diagnoses, Termination HCAM Score, HCAM Change Score, Subsequent Treatment at AFC or Elsewhere) a stepwise regression indicated that the Number of Termination Diagnoses accounted for the largest amount of AFI score variance (21.7%), $\beta = -.466$, $p < .01$. In other words, it was not just the presence of a psychiatric diagnosis at termination that predicted the level of adult functioning in the long-term; rather it was the co-occurrence of multiple diagnoses at the conclusion of treatment in childhood that best predicted adult outcome. Here too the beta was negative indicating that the greater the number of diagnoses at termination, the lower the AFI score in adulthood. It is interesting to note that this variable was a more powerful predictor of adult outcome than the child's global functioning score at conclusion of treatment (Termination HCAM).

6.1.4 The predictive power of assessment and termination variables in relation to adult functioning

After looking at assessment and termination variables separately, both sets of variables were analyzed together in order to see whether either of the two time periods took precedence over the other in predicting long-term adult outcome and whether, perhaps, a combination of variables from both categories better predicted AFI scores.

1. Child & Clinical Variables versus Termination Variables. Using a forced entry of all of the Child & Clinical Variables taken at assessment and all Termination Variables from the conclusion of treatment, a stepwise regression indicated that only Patient HCAM at assessment significantly predicts adult functioning. As in previous analyses, this variable explained 22.2% of the variation and emerges repeatedly as the best predictor of AFI scores, $\beta = .471$, $p < .01$. It is interesting to note that when examining pre- and post-treatment variables, the latter did not emerge as better predictors of adult functioning. Rather, it was the pre-treatment variable that assessed global functioning (patient HCAM score) that best predicted adult functioning.

2. Before and After HCAM Scores. A second stepwise regression looked solely at the child's before and after global HCAM scores in order to explore their relative power in predicting adult outcome. The results of the analysis indicated that HCAM score at assessment is a better predictor of long-term adult functioning than the child's functioning level at the end of treatment (Termination HCAM), $\beta = .471$, $p < .01$.

3. Before and After General Diagnoses. Using a forced entry of five variables that assess diagnostic issues (Presence of Psychiatric Disorders Prior to Assessment, Number of Referral Diagnoses, Number of Learning Difficulties, Presence of a Termination Diagnosis, and Number of Termination Diagnoses), a step-wise multiple regression indicated that the Number of Termination Diagnoses accounted for the largest amount of AFI score variance (21.7%). In contrast to the above analysis, here a termination rather than assessment variable better predicted adult functioning.

6.1.5 Treatment variables

The last set of variables explored the treatment variables (including Session Frequency, Length of Treatment, Parent Guidance, and Reason for Termination of Treatment) as predictors of adult outcome. Interestingly, none of the treatment variables demonstrated a significant correlation to the AFI scores. So, too, none of the treatment variables emerged as significant predictors of adult outcome on the AFI in the step-wise regression analyses.

This trend was further supported by stepwise regressions that looked at treatment variables first in conjunction with Child and Clinical variables and then in conjunction with termination variables. In both regressions, treatment variables did not emerge as significant factors that contribute to the prediction of adult outcome. Instead, the previous variables found to best predict outcome at assessment and termination again emerged as the more powerful predictors of AFI scores. In other words, Patient HCAM at assessment ($\beta = .471$, $p < .01$) and the Number of DSM Diagnoses at Termination ($\beta = -.466$, $p < .01$) consistently appear as the most relevant predictors of long-term adult functioning even when taking treatment variables into account, explaining a roughly similar amount of the variance in AFI scores (22.2% and 21.7%, respectively).

6.2 PATHWAYS BETWEEN POOR GLOBAL FUNCTIONING IN CHILDHOOD AND ADULT OUTCOME

One of the central findings of the current study is that the best predictor of adult outcome is a child's overall level of global functioning (HCAM assessment score) *before* receiving treatment (see section 6.1.2.B.1). Children with less than adequate functioning levels prior to psychoanalytic intervention, ranging from significantly to mildly impaired (41-70 HCAM scores), tended to remain poorly functioning adults (AFI scores below 80), despite therapeutic intervention in childhood. Indeed, of the 33 subjects whose assessment HCAM scores were 70 or below, approximately two-thirds (n = 20) received AFI scores below 80. Moreover, individuals whose global functioning at the end of

treatment had improved did not necessarily maintain these gains into adulthood. In fact, of the 12 subjects whose termination HCAM scores were above 70, just over half (n = 7) maintained this improvement into adulthood (with AFI scores above 80). However, there is a group of individuals (n = 11) who, despite an expected poor adult outcome due to low assessment HCAM scores, managed to transcend their high-risk status. These individuals, nearly one-third of the sample, overcame their poor prognosis and received AFI scores of 82 and above. A detailed list of the subjects' assessment and termination HCAM scores, AFI scores, and attachment classification assignments is presented in Appendix 6.3. In light of these findings, this section explores the pathways between poor childhood prognosis and adult outcome in an attempt to clarify some of the mechanisms affecting negative versus positive adult functioning.

6.2.1 From poor global functioning in childhood to poor adult outcome

A closer look at the breakdown of HCAM and AFI scores presented in Appendix 6.3 reveals that the four individuals whose global childhood functioning was assessed as severely impaired (assessment HCAM scores ranging from 41-50) were the same subjects with the poorest overall functioning scores in adulthood (subjects 001, 399, 123, and 390). In other words, within the current sample, those individuals whose overall functioning was the lowest in childhood, before commencing treatment, remained the poorest functioning in adulthood, despite long-term treatment in childhood. This is a sobering finding as it raises questions regarding the ability of psychotherapeutic intervention in childhood, in this case psychoanalysis, to help severely troubled youngsters to overcome, or at least lessen the intensity of their troubles in the long-term. The findings suggest that there may be a level of psychopathology or functioning below which therapeutic intervention is ineffectual. In the AFC retrospective study, Fonagy and Target (1994, 1996) reported that not all children were equally helped by intensive psychoanalysis. Based on the current findings, it may be that there is a qualitatively different level of pathology that is immune to psychoanalytic intervention. This concurs with Fonagy and colleagues (2002) who concluded that generic treatment is no longer a viable option for mental health service providers in that not all individuals are helped by the same forms of treatment.

Pathways from poor global functioning in childhood to poor adult outcome: 4 case studies

A more in-depth look at these four individuals sheds interesting light on both their childhood and adulthood predicaments. First, as mentioned, they all received very low scores on their assessment HCAM, all in the 41-50 range, indicating significantly impaired functioning. As adults, their AFI scores ranged from 30-55. The next lowest AFI score among this sample was 63, perhaps indicating that below 60 on the AFI is akin to scoring below 50 on the HCAM and that scores in this range reflect extremely poor functioning abilities, suggesting a lifetime of significant impairment. Such individuals may likely require repeated psychiatric help throughout their lives or some sort of comprehensive support system that enables them to manage. These findings lend support to the critical importance of preventative interventions, as early as infancy, as urged by Fonagy (1998). Minimizing suffering to such individuals not only ensures an improved quality of life for them and their families, but also reduces the strain and cost to mental health services.

Looking at their childhood and adulthood data, certain common variables emerge. All four subjects are male, with above average intelligence, and all participated in the follow-up interviews when they were in their early 30's. Three were referred to the AFC in latency, and one in adolescence. All received lengthy treatment ranging from 1.5 to 4.5 years. Two received non-intensive treatment while two received intensive psychoanalysis. In addition to their very low HCAM scores, the four subjects all presented at referral with multiple diagnoses, ranging between three and five in number. There was insufficient information in the childhood files to determine whether two of the subjects met criteria for DSM diagnoses at the end of treatment. However, the two for whom information was sufficient met criteria for multiple diagnoses at termination as well. These findings highlight the significance of comorbidity and its association with long-term psychopathology (see section 2.6.1).

Furthermore, change in HCAM score from assessment to termination was nonexistent (i.e. zero point change), minimal (2 points) or negative (-13 points) for three of the four subjects, meaning that global functioning hardly improved or indeed worsened at the end of treatment. Given the length and intensity of the treatment, a poorer or stagnant global functioning score at the end of treatment as compared to referral is indeed worrisome.

Several possible questions arise in light of these findings. On the one hand, it is possible that without treatment, these individuals would have deteriorated far more precipitously; perhaps treatment kept further deterioration at bay. On the other hand, it is also possible that treatment gave the illusion of help when no significant changes in functioning actually took place. Neither conjecture can be proven within the framework of the current study. However, taken together with the presence of multiple psychiatric disorders at the end of treatment, the findings illustrate the tenacity of their pathology.

It is perhaps not surprising, therefore, that these four subjects also met criteria for multiple Axes I and/or Axis II DSM diagnoses in adulthood. More strikingly, they are also the four subjects with the poorest SCID-II symptom count and represent the only subjects in this study who met criteria for Axis II personality disorders. As mentioned in section 5.2.1, only three of the 34 subjects participating in this study met criteria for a personality disorder. An additional subject was rated sub-threshold for eight Axis II disorders. Again, these are the same four individuals with the poorest assessment HCAM score in childhood and the lowest AFI scores in adulthood. Although the literature has leveled criticism at the formulation behind Axis II disorders (see, for example, Clarkin, Kernberg & Somavia, 1998; Vaillant & McCullough, 1998; Westen & Shedler, 1999a, 1999b), evidence from the current study would seem to indicate that the diagnosis of a personality disorder most definitely picks up on a significant level of impairment, one that distinguishes well-functioning individuals from those who are not.

Two additional adult variables related to attachment status and life events are of interest. All of the four subjects were rated as insecure in relation to attachment; three were assigned to the enmeshed/preoccupied sub-group while one was assigned to the dismissing sub-group. In addition, one received a primary classification of 'unresolved' on loss followed by a preoccupied classification. Reflective functioning scores ranged from −1 (minus one) to 4, representing the lower end of the RF scale. These findings are in keeping with the literature that underscores the relationship between security of attachment and positive functioning, not only in childhood but also in adulthood (Cyranowski, 2002; van IJzendoorn & Bakermans-Kranenburg, 1996; Mickelson, Kessler & Shaver, 1997; Strauss, 2000). Significant impairment in functioning was demonstrated across all domains, although the two subjects with higher AFI scores (54 and 55) did manage to maintain an island of functioning in the work domain. However,

their behavior in this area did raise a fair amount of concern. They also were able to describe two or more friends with whom they interacted regularly, shared similar interests, and with whom they had a mutually supportive relationship. However, the friendship domain was often characterized by discord and their friends came across as individuals suffering from their own rather severe emotional difficulties.

In keeping with the literature and the findings presented in Chapter 5, these four individuals had experienced a high number of severe life events in the five years prior to the follow-up interviews (2-9) relative to this sample, alongside very poor coping skills. In addition, all demonstrated severe difficulty in the area of intimate relationships. At the time of interview, two of the four men were living with one or both parents; one had never left home successfully. Another subject shared a flat with some friends, and one shared a flat with a woman with whom he had a highly unusual relationship. Although he referred to her in romantic terms and reported a sexual relationship with her, the woman was significantly older than he, with a child his age, and it appeared that most of their relationship was based on a shared and rather vague business venture. In addition, she seemed to fulfill many maternal roles on his behalf (food, laundry, etc.). Indeed, the subject stated that because of his unusual sleep patterns, he and his partner were hardly awake at the same time, an arrangement that by definition precluded both emotional and physical intimacy. Overall, these subjects presented a life in which they had little capacity to plan for or invest effectively in most if not all areas. They were also highly dependent on parents or others to look after, manage and contain both their physical and emotional needs. Appendix 6.4 presents the case histories of these individuals in greater detail in an attempt to better understand the depth of their adult disturbance and apparent inability to benefit in the long-term from psychoanalytic treatment in childhood.

Clearly, the individuals described above represent the more severely disturbed extreme of the current sample and exemplify the way in which poor initial global functioning in childhood is predictive of poor long-term outcome. The highly disturbed nature of their adult disturbance seems to indicate that there is a level of psychopathology that is qualitatively different in its lack of responsiveness to psychoanalytic intervention in childhood. Indeed, the life histories of these individuals raise serious questions regarding the extent to which treatment of any kind can be helpful, highlighting the importance of matching appropriate and effective treatments to individuals suffering

from specific types or degrees of disturbance. Finally, they underscore the need for meaningful preventive interventions that help individuals to develop in psychologically healthy ways not only in childhood but across their life span, reducing long-term personal suffering and extensive depletion of mental health resources.

6.2.2 From poor childhood functioning to positive adult outcome: The role of secure attachment

Although children with low assessment HCAM scores were most likely to end up as poorly functioning adults, this was not the case for roughly a third of the sample (n = 11) who despite poor prognosis, turned out to be well-functioning adults. As section 6.2 discusses, adequate to good termination HCAM scores did not necessarily guarantee high functioning scores in adulthood (AFI scores above 80). Instead, common to all the individuals with low functioning in childhood (assessment HCAM < 70) who grew up to be high functioning adults was a secure adult attachment status (see Appendix 6.3). Remarkably, all of the individuals who seemed to transcend a gloomy prognosis based on their pre-treatment levels of global functioning were securely attached in adulthood. Table 6.2 illustrates the strong association between secure attachment and adult functioning, despite poor global functioning in childhood.

Table 6.2. Frequency of securely attached subjects relative to assessment HCAM and AFI scores.

AFI score	Assessment HCAM score		Total
	< 60	>60	
< 80	1	0	1
>80	9	3	12
Total	10	3	13

A hierarchical log linear analysis found a significant association between AFI and a secure attachment status ($\chi^2 = 11.68$, df = 2, $p < .0086$). It also found a three way

association between AFIxHCAMxAAI ($\chi^2 = 6.34$, df = 3, p <.02), suggesting that individuals with high AFI scores and low HCAM scores were more likely to be rated secure on the AAI. This finding suggests that security of attachment may play a pivotal role in the development from poor childhood prognosis to positive adult outcome. Despite the strong relationship between poor global functioning in childhood and poor adult outcome, about one-third of the sample managed to break this cycle. Common to all cases was a secure adult attachment status, supporting the important mediating role of attachment in altering the long-term outcome of childhood disturbance and in enabling a healthier and higher level of adult functioning. The case studies of two follow-up subjects who despite low assessment HCAM scores were able to overcome their difficulties and maintain treatment gains into adulthood are now presented.

6.2.3 Pathways from poor childhood functioning to positive adult adaptation: Two case studies

a. The case of Ms. S.

Ms. S. (152) received long-term, intensive psychoanalysis in adolescence due to a moderately impaired level of functioning at referral. At the end of over 4 years of treatment, Ms. S. was symptom free, no longer met criteria for a psychiatric disorder, and was functioning well across several domains. These gains seem to have been maintained into adulthood as assessed in her adult follow-up interviews.

Presentation at referral:

Ms. S. was referred to the AFC by her GP following an appointment made by Ms. S.'s mother who was very concerned about her. According to mother, Ms. S. seemed depressed, was experiencing sleeping difficulties and was complaining of loneliness and a lack of friends. Although Ms. S. was an excellent student academically, it appears that from the beginning of primary school other children were treating her unkindly and Ms. S. seemed unable to make friends. In her final year of primary school this situation affected her school attendance and she complained of extreme unhappiness. Her social isolation and lack of friendships continued in secondary school, leading eventually to her referral to the AFC. At the time of referral, mother described Ms. S. as depressed, lonely,

unhappy at school and at home, uncommunicative, withdrawing to her room and unable to tell her parents what was bothering her. In addition, she had become very clingy, demanding physical contact and affection from mother. So, too, her mother reported intense rivalry between Ms. S. and her younger sister, often leading to very fierce fighting.

During Ms. S.'s assessment, she expressed latent suicidal ideation, along with fears of madness. Although Ms. S. wanted to begin analysis, she also feared it as a confirmation of her madness. She experienced constant and recurrent daydreams leading to partial withdrawal from reality, daydreams that Ms. S. found extremely frightening. The therapist speculated that the content of the daydreams were sexual and grandiose, arousing severe anxiety in Ms. S. Although some of her difficulties were understood as being related to the developmental pressures of adolescence, the therapist assessed Ms. S. as suffering from cumulative developmental interferences leading to distorted personality development, with marked narcissistic and depressive disturbance. Ms. S. was assessed retrospectively to have a global functioning score (referral HCAM score) of 55, reflecting moderately impaired functioning.

Family background:

Ms. S.'s parents are Jewish. Mother was raised in the UK and father was raised in Germany during WWII; he is an only child. Both sets of grandparents are alive, although Ms. S. does not have a particularly close relationship with any of them. The maternal grandfather suffered from mental illness throughout his life, although Mother was unsure of diagnosis. In recent years, he had been in and out of mental hospitals repeatedly. The relationship between Ms. S.'s parents has apparently always been fraught with tension. However, this tension was particularly intensified following the birth of each of the children. At the time of the referral, Father was able to perceive of his sense of rivalry with his children which led him to be obsessively controlling and demanding of his wife. Parents described the first five years of Ms. S.'s life as extremely difficult and the pressures on mother eventually led to a major depressive disorder (MDD). During this time Ms. S.'s brother and mother developed asthma. Ms. S.'s father also reported suffering from MDD in the past. In addition, he reported having received psychological treatment at an outpatient clinic due to anxiety, low self-esteem and depression. Neither parent met criteria for a psychiatric disorder at the time of referral.

Ms. S. is the middle of three children. Nothing untoward is reported regarding her pregnancy, birth or early development. Both parents recall her being a very willful child with a tendency toward violent tantrums, screaming, kicking and generally inconsolable from the age of two. Ms. S.'s inability to share her feelings and needs with her parents seems to have been persistent throughout her childhood and from an early age. This provoked a sense of extreme guilt and sense of failure in mother who tended to respond to Ms. S.'s difficulties with concrete and practical solutions but who seemed unable to offer her emotional comfort. Father continued to see Ms. S. as strong-willed and stubborn and felt very hurt by her unwillingness to accept care and attention from him.

Treatment and termination:

Ms. S. received intensive psychoanalysis (five sessions per week) for a period of 4.25 years. Treatment was terminated by mutual agreement of therapist, parents and Ms. S. Her global functioning at termination was assessed retrospectively as within the adequate functioning range (termination HCAM score of 75), indicating an improvement in functioning of 20 points from referral to termination. A thank-you letter sent by mother refers to Ms. S.'s competent functioning at work and in relation to her parents and sister. So, too, mother remarked on Ms. S.'s tremendous increase in self-confidence.

Adult follow-up interviews:

At the time of the follow-up interviews, Ms. S. was in her mid-thirties. She was living with a steady partner with whom she had been cohabiting for nine years. She was employed in a computer-related profession, had completed doctoral level studies, and described several close friendships, along with a range of interests and hobbies that were a source of pleasure to her. Ms. S. had not experienced any severe life events in the five years prior to the interviews, nor did she report severe adversity at any point in her adult life. Ms. S. appeared to be functioning well across a range of domains, although there was some difficulty related to her work situation and intimate relationships. Overall, she has planned the changes and transitions in multiple life domains. Ms. S. did not meet criteria for a personality disorder. She had experienced two episodes of minor depression in adulthood, both times due to anxious and depressive symptoms related to stresses in her studies and intimate relationships. In both instances, Ms. S. sought professional help and received psychotherapy for a period of 4 months at age 23 and for approximately one

year at age 32. Interestingly, in discussing her analysis at the AFC, Ms. S. felt that the therapy she had in adulthood had made 'incredibly rapid progress' due to her earlier treatment at the AFC. Ms. S. was assessed as securely attached and received a very high reflective functioning score of eight points.

Looking back on her presentation in adolescence, it seems that her lengthy and deeply entrenched social isolation ceased to characterize Ms. S.'s personality and that since treatment she has been able to develop and maintain meaningful friendships and intimate relationships that are mutually supportive. Although Ms. S. tends to experience anxiety and depressive symptoms when faced with stress, she is able to identify her emotional state and seek appropriate professional help. Indeed, the withdrawn and reticent adolescent who seemed unable to share her emotions with anyone seems to have developed into a highly reflective individual, in touch and open with her feelings, skills which would seem to buffer her against severe emotional disturbance.

b. The case of Ms. Z.

Presentation at referral:

Ms. Z. (175) was referred to the AFC by a child psychiatrist who had been approached by Ms. Z.'s parents when she was ten years old. Despite above average intelligence, Ms. Z. was underachieving in her school work, demonstrating particular difficulty with both reading and writing. At age ten she was assessed as having a reading age three years below her chronological age and displayed extreme confusion even in writing her own full name. Her learning difficulties were associated with disruptive and difficult behavior at school. In addition, Ms. Z.'s parents reported that Ms. Z. was displaying some very dependent traits at home, needing her old pacifier, a sleeping bag and an old cloth diaper (transitional object) that she needed in order to fall asleep at night. She had recurrent nighttime fears and slept with an ice axe in her room in case anyone (lions, tigers, ghosts) should be under her bed. She needed a light to be left on in the corridor in order to sleep at night and reported frequent nightmares. During the assessment process, Ms. Z.'s parents also described some additional worries regarding Ms. Z.'s behavior. In particular, they described frequent scenes in which Ms. Z. would display spiteful and vindictive behavior at home in which she would bite, kick and hurl verbal abuse against mother and sister. She seemed to vacillate between periods of "difficult, rude and curt

behavior" in which she would attack others and periods in which she would crawl into her sleeping bag, suck her pacifier and sleep for long stretches of time.

Based on her case notes, Ms. Z. was retroactively assessed as meeting criteria for multiple psychiatric disorders. Her primary diagnosis was overanxious disorder of moderate severity, co-occurring with oppositional defiant disorder of mild severity, and specific developmental reading and writing disorders. Her global functioning at assessment received retroactively a score of 55 on the HCAM, indicating a moderately impaired level of functioning. It is unclear from the case notes whether Ms. Z. continued to meet criteria for these or other disorders at termination. In addition, her case notes did not indicate the reason for treatment termination. As a result, her termination HCAM score could not be assessed retroactively.

Family background:

Ms. Z. grew up in a middle-class family, living with her mother, father and older sister. Both parents described themselves as having experienced extremely difficult childhoods, and seemed to have suffered a fair degree of emotional deprivation that, according to the therapist, had "left them with noticeable scars." Mother's parents had an extremely unhappy marriage characterized by continual warfare with constant rowing and screaming. When mother was 15 years old her father left the family. Mother described this as a total loss of her father. At the same time, mother began to take charge of her own mother and of the family finances. From that time onward, mother described herself as a 'coper' upon whom others depended. Although mother and her husband described mother as a highly competent and organized 'coper', during the initial sessions at the AFC mother broke down completely, seeming extremely vulnerable and fragile. She described multiple depressive episodes, including postpartum depression following the birth of Ms. Z.'s sister and when Ms. Z. was 4 years old. In the latter instance, the family GP sat by mother's bed for three consecutive nights and prescribed valium. The therapist found father to be "very precariously held together", fighting to control his feelings. He described a very traumatic childhood in which his mother had been raped by her own father, marrying a man more than 20 years her senior in order to escape from home. Father described his mother as "mad, evil and very mean". In contrast, he adored his father despite his "weak character" and continued to mourn him in the six years since his death.

At the time of referral parents had severe marital difficulties. Throughout their relationship Mother was seen as the competent carer who held the marriage together. In contrast, father was unable to give her the support she needed. Although both parents wanted to have children, father could not stand babies and found their crying irritating. Both parents found the assessment process to be an emotional ordeal and seemed to want to be told that in fact Ms. Z. was not suffering from any emotional distress. Mother and father aroused considerable concern in the therapist who assessed both parents as being in a very fragile emotional state. Both parents received retroactive global functioning GAF scores reflecting a mild impairment in functioning (Mother 70 and Father).

Childhood background:

Ms. Z. was born prematurely, by Caesarian section, weighing just over four pounds. At birth, Ms. Z. was rushed to a special care unit and was not expected to survive due to respiratory problems. Ms. Z.'s sister visited mother shortly after the birth and turned out to have an infectious illness. As a result, Mother was not allowed to see Ms. Z. for five weeks while Ms. Z. remained in the hospital. Once home, parents described Ms. Z. as a very good baby, feeding and sleeping regularly. Mother, however, thought that her early hospital regimentation had deprived Ms. Z. of affection and physical contact which mother tried to make up for. Ms. Z. reportedly met her developmental milestones very early despite her pre-maturity. At age one, Ms. Z.'s maternal grandmother bought her a little sleeping bag to which Ms. Z. became immediately attached. Around the same time she was given a pacifier and walked around with a cloth diaper which she used to comfort herself.

Assessment, treatment and termination:

The therapist described Ms. Z. as being extremely self-possessed in both her diagnostic interviews. However, she displayed two very different sides of her personality in them. In the first interview, Ms. Z. seemed to have experienced the therapist as persecutory. In the second, Ms. Z. was teasing and provocative toward the therapist. The therapist felt that Ms. Z. had demonstrated both the little girl who was frightened and vulnerable underneath, and the controlling child with sad-masochistic personality characteristics as expressed in her provocative and argumentative behavior. Ms. Z. seemed to have a pronounced learning inhibition which the therapist felt was linked to poor narcissistic investment in her self as well as with inadequate or negative parental expectation of her.

Although intensive, five times a week treatment was perceived as the treatment of choice, the therapist thought the parents would not be able to tolerate that degree of intervention and therefore recommended three times a week sessions. Soon after treatment onset, Ms. Z. began receiving four sessions per week. Treatment continued for a period of eighteen months. In her concluding week of treatment, Ms. Z.'s therapist noted the difficulty in providing analysis given the highly problematic family situation. Father had had an affair with another woman and had introduced his daughter to her, swearing them to secrecy from mother. Ms. Z., unable to keep the secret from mother, confessed to her. In her last two sessions, Ms. Z. asked to include her mother and sister in the meetings. In both sessions, Ms. Z. seemed to be out of touch with her feelings, unable to discuss her pain, disappointment and sense of betrayal from father. In a follow-up session with both parents, father appeared highly disturbed and mother refused to have him back without professional help for their marital difficulties. Ms. Z. had decided to go to boarding school due to the highly disturbed family atmosphere and had apparently settled in nicely and was enjoying herself at school. Based on the adult follow-up interviews, we know that Ms. Z.'s parents divorced soon after (when Ms. Z. was eleven years old) and she became increasingly distant from father as she became more involved with her peer group.

Adult follow-up interviews:

Ms. Z. participated in the follow-up interviews at age 29. At the time she was married, living in Scotland, far from parents and sister. She came across as a lively and dramatic character with an outgoing personality. Beneath her vivacious and somewhat histrionic façade, one senses a more sensitive, serious and stable personality, an individual capable of intimate and supportive relationships with adaptive and skillful coping skills. Reading through the transcripts of her follow-up interviews, one senses that she has chosen not to dwell on the past, to focus only on the positive aspects of her childhood, and to invest her interests and energies in the present and future.

During her adult life, Ms. Z. had not suffered from psychiatric disturbances nor did she meet criteria for a personality disorder (although she was rated sub-threshold for histrionic). In general, her physical health had also been very good and she did not report severe adversity during adulthood. Although she had experienced some moderately severe life events in the five years preceding the adult interviews, half related

to family members and not directly to her. Ms. Z. appears to function well across all the domains assessed, having actively planned the changes and transitions in all areas of her life. In addition, she received moderate to excellent coping scores across domains, even in relation to severe life events.

Ms. Z.'s memories regarding her childhood treatment are somewhat vague and she is not at all sure that the treatment helped her at the time or later in adult life, but chose to participate in the study out of a sense that the results may be helpful to someone else down the road. She has not felt the need for therapy as an adult, but did seek professional marital advice concerning sexual difficulties her husband was experiencing. In reviewing Ms. Z.'s case, one has the sense that a great deal of her difficulties were caused or exacerbated by her parents' turbulent relationship and that once father left the family home, combined with Ms. Z.'s decision to go to boarding school, Ms. Z. was able to distance herself from her troublesome home life and begin to invest in both academic and social arenas. With the support of her mother, Ms. Z. was able to discover and excel in a career path suited to her creative and social skills. Without an assessment of the treatment process, it is difficult to attribute the dramatic change that Ms. Z. underwent, from a deeply frightened and provocative girl to a confident, productive and well-adjusted adult. One is left wondering whether the treatment setting offered an island of relative peace within the stormy turbulence of her home life and whether it enhanced her inherent strengths and abilities, enabling Ms. Z. to extricate herself from her disturbing background and to invest productively in her own development.

Although Ms. S. an Ms. Z. come across as very different personalities, both were referred to treatment because of an inability to invest productively in crucial aspects of functioning and, as a result, were unable to realize their full potential. In addition, both exhibited a severe level of emotional distress at referral. Common to both of them is a dramatic turn around from childhood to adulthood in which earlier inhibitions (social for Ms. S. and academic for Mr. Z.) no longer hindered their psycho-social development. Although Ms. S. and Ms. Z. utilize different coping or defense mechanisms (Ms. S. seems to reflect upon her difficulties (RF score of 8) and seek professional help when necessary whereas Ms. Z. tends to put them behind her and move on (RF score of 5), both seem to have found effective ways for dealing with distress. In addition, despite very troubled and perhaps insecure relationships with their primary caregivers, both have

developed supportive intimate relationships in adulthood and were assigned a secure attachment status in adulthood. Without an in-depth analysis of the their treatment process, which clearly falls beyond the scope of this study, it is hard to determine which aspects of their treatment led to the significant changes in their personalities or psyches. Both, however, seem to have benefited immeasurably from psychoanalytic intervention in childhood. Their case histories would seem to support the invaluable and long-term cost-effectiveness of early intervention. Future outcome research that examines the therapeutic process may shed important light on the precise aspects of treatment that seem to contribute to the development and maintenance of meaningful long-term change. One important area of investigation relates to the ability of psychotherapy to alter an individual's attachment status from insecure to secure. This theme is explored in the following section.

6.3 THE RELATIONSHIP BETWEEN CHILDHOOD VARIABLES AND ADULT ATTACHMENT STATUS

Given the strong association between positive adult functioning and a secure attachment status for subjects at risk for long-term psychosocial disorders, the relationship between specific childhood variables and adult attachment status was explored. For this purpose, MANOVAs were conducted for each set of childhood variables described in section 6.1 (including Demographic & Family, Parents' Mental Health and Global Functioning, Child & Clinical, Treatment, and Termination Variables - see Appendix 6.1 for detailed list) in order to see whether the three attachment groups (F, D & E) differed significantly from each other. None of the MANOVAs yielded significant differences among the three AAI groups. However, further analyses (ANOVAs) on each individual childhood variable highlighted three childhood variables regarding which the three attachment groups differed significantly. First, among the clinical variables, the Number of Learning Difficulties yielded significant differences between the insecure/preoccupied group and both the insecure/dismissing and secure groups, $F(2,31) = .387$, $p < .01$. A post-hoc multiple comparison analysis using the Bonferroni method found that the preoccupied group had a greater number of learning difficulties in childhood than either the dismissing or secure groups. In other words, subjects with a preoccupied attachment

classification in adulthood had a greater number of learning difficulties in childhood (at assessment time) than either the insecure/dismissing or the securely attached subjects.

ANOVA analyses found two additional childhood variables for which the attachment groups demonstrated significant differences; both pertain to Termination Variables. The first variable relates to Termination HCAM score, in which the insecure/dismissing group had a significantly higher score than the insecure/ preoccupied group, $F(2,31) = 4.043$, $P < .05$. So, too, change in HCAM score from assessment to termination (HCAM Change Score) was significantly higher for the insecure/dismissing group as compared to both the insecure/preoccupied and the secure groups, $F(2,31) = 5.906$, $p < .01$. A post-hoc multiple comparison analysis using the Bonferroni method found that the dismissing group had a higher termination HCAM score in childhood than the preoccupied group. In addition, the dismissing group demonstrated a greater change in pre- and post-treatment HCAM scores than either the insecure/preoccupied or the secure groups. In other words, subjects with a dismissing attachment classification in adulthood demonstrated better global functioning at the end of treatment in childhood than the preoccupied adults. Moreover, the dismissing group showed a relatively greater increase in global functioning during the course of treatment in childhood than either the preoccupied or securely attached subjects.

In addition to the above analyses, discriminant function analyses were conducted to determine which combination of childhood variables predicted group membership in the three primary attachment classifications (F, E, and D). In the first analysis, two functions emerged as significantly discriminating between the three primary attachment groups (secure, insecure/preoccupied and insecure/dismissing): Parent Guidance ($p < .01$) and Number of Learning Difficulties ($p < .01$). Table 6.3 presents the eigenvalues of the two functions, with Parent Guidance (Function1) explaining 40.83% of the total variance and Number of Learning Difficulties (Function 2), explaining 19.89 %. Table 6.4 presents the two functions' standardized coefficients.

Table 6.3. Eigenvalues for two childhood functions predictive of attachment classification

Function	Eigenvalue	Canonical correlation	% of total variance
1 - Parent guidance	.689	.639	40.83
2 - No. of Learning Difficulties	.249	.446	19.89

Table 6.4. Standardized Canonical Discriminant Function Coefficients

	Function	
	1	2
1 – Parent guidance during treatment	.845	.597
2 – Number of learning difficulties	-.794	.663

The coefficients indicate that the more parent guidance received during treatment and the fewer the child's learning difficulties, the more positive the function score. Conversely, less parent guidance received and greater number of learning difficulties resulted in a more negative function score. Specifically, subjects classified as insecure/dismissing were likely to have more parent guidance and fewer learning difficulties, whereas insecure/preoccupied subjects were likely to have less parent guidance and a greater number of learning difficulties. The secure subjects, in contrast, were likely to have more parent guidance and a greater number of learning difficulties. Based on these two functions, the analysis revealed that roughly two-thirds of the sample (67.6%) was correctly classified. In particular, 88.9% of the dismissing subjects (8 out of 9) and 76.9% of the secure subjects (10 out of 13) were classified correctly in contrast to only 41.7% of the insecure/preoccupied subjects (5 out of 12).

A second discriminant function analysis examined whether particular childhood variables would correctly predict assignment to either organized (secure or insecure groups) or disorganized (unresolved on loss or abuse or 'cannot classify') attachment classification groups. In this analysis one variable emerged as a significant

discriminating function between the groups, namely Length of Treatment (in years), p < .01, with an eigenvalue of .275, explaining 21.5% of the total variance. Table 6.5 presents the function coefficients for the organized and disorganized attachment groups. These findings demonstrate that subjects with a disorganized adult attachment status had significantly lengthier treatment in childhood than their organized counterparts.

Table 6.5. Discriminant function coefficients for organized and disorganized attachment groups

	Attachment classification	
	Organized (D,E,F)	Disorganized (U, CC)
Length of treatment (yrs.)	1.412	2.235
Constant	-2.098	-5.210

6.4 CHILDHOOD PREDICTORS OF ADVERSITY

In light of evidence demonstrating a relationship between childhood variables and adult adversity (Champion et al., 1995), regression analyses were conducted on the childhood predictors of severe adult life events. When the full 32 childhood variables were entered into the regression none emerged as significant. So, too, when childhood variables were entered by group (i.e., demographic and family variables, parents' mental health and global functioning, child and clinical variables, treatment variables, termination variables), no significant regressions emerged. Step-wise regressions also did not find significant results. However, when gender, age at start of treatment, and IQ were entered together into the regression, a significant result was found. This result indicated that female subjects had a significantly higher number of severe life events than their male counterparts (ß = .375, p = .026).

6.5 DISCUSSION

6.5.1 The relationship between childhood factors and adult outcome

a. The research context

The first part of this chapter examined the relationship between childhood variables and adult outcome as measured by the AFI, with particular focus on two childhood periods: assessment (before commencement of treatment) and termination (at the conclusion of treatment). Before summarizing the central findings presented in this chapter it is important to mention several points. First, a great deal more information concerning childhood variables was available for the assessment as compared to the termination time period. Assessment variables included several domains such as Demographic and Family Variables, Parents' Mental Health and Global Functioning Variables, and Child and Clinical Variables. In contrast, the termination time period was limited to five variables. Second, despite the relatively greater wealth of data related to the assessment period, in fact several variables from this time period could not be expected to yield meaningful results given the overwhelming homogeneity of the data. This was true for all of the Demographic and Family Background with the exception of those variables specific to parental mental health and global functioning. So, for example, all but six of the subjects' families were rated as belonging to the upper two socio-economic brackets on the RGC, rendering any comparisons non-meaningful. Similarly, all but five of the subjects' parents belonged to one of two religious groups. Although the latter variable pertaining to religious group is perhaps of less concern to a study looking at the long-term impact of psychoanalysis in childhood, socio-economic status has frequently been highlighted as a significant risk factor in child development (Rutter et al., 1976; Offord, Boyle, Szatmari et al., 1987). The findings of the Rochester Longitudinal Study (as cited in Sameroff and Seiffer, 1990) indicated that children from poor and minority group families are at even greater risk for general developmental problems than are families with maternal psychiatric illness, and that the combined risk of parental mental illness and low social status appears to produce the worst child outcomes. Similarly, in the AFC retrospective study, social class and whether the child's family was broken or intact were associated with reliable improvement in HCAM scores across the full sample (Target,

1993). As mentioned, however, these important variables could not be studied in the current sample. Future outcome research examining a larger and more varied population should, therefore, include these demographic variables, many of which have been found relevant to long-term development.

In a similar vein, the four treatment variables examined in the study did not yield significant findings. This contrasts with the findings of the AFC retrospective study that found session frequency, length of treatment, parent guidance and concurrent analytic treatment of mother to be important predictors of treatment outcome (Fonagy & Target, 1996). This difference in findings can be explained by several factors. First, the current sample's homogeneity within each treatment variable most likely precluded the emergence of any significant findings in relation to long-term adult adjustment. In the particular sample followed up into adulthood, too few children had parents who received concurrent psychoanalysis (3.9%) to enable the inclusion of this variable in the study. Regarding frequency of sessions, roughly two-thirds of the subjects had five times a week analysis, four subjects had four times a week treatment and eight subjects experienced non-intensive treatment (1-3 sessions per week). Thus, session frequency could not be explored in a meaningful manner. Since subjects who received less than six months of treatment were excluded from the study, the overwhelming majority of subjects received, on average, lengthy treatment (i.e. 2.84 years). Only one subject had less than a year of treatment and the majority had between one and four years. Clearly, because of the small sample size, comparisons based on the number of years of treatment were not meaningful, although in a much larger sample the difference between one and four or more years of psychoanalysis may very likely yield significant results. Indeed, additional studies on the outcome of psychoanalysis have reported a dose-response effect in which longer treatment led to better outcome (Bachrach, 1993; Kordy, von Rad & Senf, 1983).

A second explanation relates to the primary focus of the current study. Although the follow-up study was intended to be an initial, albeit cautious, look at the long-term effects of psychoanalysis in childhood, it was not designed to assess the actual characteristics of psychoanalytic treatment that lead to short or long-term gains. In keeping with its primary focus, none of the outcome measures were designed to assess specific characteristics of the treatment received in childhood. This is, however, an area

worthy of investigation. Fonagy and colleagues outlined a series of themes that need to be assessed in order to better understand the way in which specific psychoanalytic 'ingredients' influence treatment outcome (Fonagy & Target, 1997). In particular, they highlighted the need for a manualization of psychoanalytic treatment to enable the assessment of intra-psychic functioning as part of psychoanalytic outcome research (see Bateman & Fonagy, in press, for a manualization of adult treatment, and Fonagy et al, 1993 for child treatment). They called for a more detailed description of the treatment process, including major analytic themes (e.g., aggression, sexuality, anxiety, identity), the child's behavior (e.g., cooperativeness, resistance, free play, speech), and the therapist's modes of intervention (e.g. interpretation of conflict, defences, transference, external events, etc.). Clearly, a more in-depth look at the role of treatment characteristics in childhood on long-term adult functioning would necessitate the development of outcome measures that go beyond the assessment of symptomatology and psychosocial adaptation.

Finally, it is also possible that immediate treatment gains are strongly influenced by factors related specifically to the nature of the therapeutic intervention (i.e., length, intensity, analysts' experience, etc.), as found in the retrospective study, but that these factors do not continue to effect the long-term functioning of patients over time. In order to examine the long-term influence of specific treatment characteristics, longitudinal studies on the long-term outcome of adults treated in childhood (ideally prospective in nature) need to be conducted. Future studies, carried out on larger samples, can explore in greater depth the long-term (if any) effects of individual treatment 'ingredients' on long-term development and functioning. As discussed above, studies with this focus would initially need to develop appropriate outcome measures before embarking on an analysis of the long-term influence of specific treatment ingredients.

b. The main findings of the current chapter

The analyses point to the child's global functioning level pre-treatment as the best childhood predictor of adult outcome. Repeatedly, Patient HCAM score at assessment emerged as the primary predictor of AFI scores. The importance of Patient HCAM at assessment was significant not only amongst the Child & Clinical variables, but also when Patient HCAM was compared to both parents' global functioning scores, to

patient's HCAM score following treatment (Termination HCAM), to Treatment variables, and to all Termination variables. As described in section 3.3, the HCAM measure is a global measure of psychosocial functioning that is based on an assessment of both positive adaptation and impairment. Similarly, the AFI provides an overall adaptation score that is based on both psychiatric symptomatology and positive functioning. It is interesting to note, however, that when examining only the child's termination variables, the Number of Termination Diagnoses proved to be the most significant predictor of adult functioning rather than their overall global functioning level at the end of treatment, as measured by the Termination HCAM score. That is to say that based on Termination Variables alone, the greater the number of diagnoses a person had at the end of treatment in childhood, the lower his or her long-term functioning in adulthood, as assessed by the AFI. Given the small sample size, however, a note of caution is in order. Despite the salience of the above findings, it is important to point out that the statistical analyses employed in the study were underpowered, due to the small number of subjects. As a result, the findings should be related to with appropriate caution. It is, therefore, recommended that future research explore the relationship between childhood variables and adult outcome on a larger sample.

The importance of including both psychiatric diagnoses alongside psychosocial assessment seems to be supported by the current findings as well as by other research (Vander Stoep et al, 2002). Indeed, the current findings do not support either the categorical or the dimensional approach in an unequivocal manner. Both the HCAM measure, which assesses adaptive functioning across 14 different areas, and DSM diagnoses which evaluates the presence or absence of specific psychiatric and personality disorders, were found to be significant predictors of adult outcome. As such, these findings support the AFI's inclusive approach to the assessment of functioning, one that combines both indicators of psychiatric diagnoses and evaluations of psychosocial capabilities across a range of domains. Given the difficulty in disentangling the assessment of positive functioning from psychiatric status, the AFI enables the incorporation of both into an overall index score. Clearly, the use of global functioning scores versus psychiatric diagnoses depends on the focus and goals of each individual study. The findings of the follow-up study support the use of the AFI alongside individual measures, enabling a single summary score in addition to ratings for specific

personality and psychiatric dimensions. However, it is recommended that the AFI be further tested in larger-scale studies in order to further examine its reliability and validity.

In addition to the salience of pre-treatment global functioning in predicting long-term adult adaptation, the findings of the current study highlight several important themes relating to the issue of comorbidity, the relative effects of parental psychopathology on child development, the possible long-term mediating influence of psychoanalytic treatment on childhood psychiatric disorders, and the complex interplay between nature and nurture in the development of adult personality. These themes are discussed below.

6.5.2 Comorbidity

Although researchers have lamented the insufficient extent of scientific investigation regarding comorbidity among children and adolescents (Fonagy et al., 2002; Jensen, 2003; Roberts et al., 1998), existing studies point to a high prevalence of co-occurring disorders within this population (i.e., Bird, Gould, & Staghessa, 1993; Achenbach, 1993, Angold & Costello, 1993, Biederman et al., 1991, 1992; and Caron & Rutter, 1991; Kendall et al., 1992). Comorbidity is apparently all the more prevalent among clinical groups (Muratori et al., 2002; Biederman, Faraone & Kiely, 1996; Giaconia et al, 1994). Indeed, several authors have reported that among children, approximately half of all diagnoses are multiple (Anderson et al., 1987; Bird et al., 1988). Increasingly, comorbidity in children has begun to receive a significant place among the risk factors associated with poor long-term outcome of childhood disorders (Fonagy et al., 2002; Hechtman, 1996; G. Weiss, 1996). Comorbidity is a complex issue that has confounded longitudinal outcome studies in the past (Weiss, 1998a, 1998b; Majcher & Pollack, 1996) and researchers increasingly have called for prospective community-based longitudinal studies to improve our understanding of its prevalence, the relationship between multiple disorders, as well as their influence on subsequent development and long-term outcome (Roberts et al., 1998; Weiss, 1996).

The results of the current study underscore the relationship between comorbidity in childhood and adult outcome. Among the termination variables, an increased number of DSM diagnoses predicted poorer performance in adulthood as measured by the AFI. As

such, the current findings support the view that the presence of multiple disorders in childhood is, indeed, a risk factor for poor functioning in adulthood. Although the literature on particular combinations of disorders is fairly extensive (see Biederman et al.'s summary on the comorbidity of childhood ADHD and other disorders, 1996; Offord and Bennett's review of comorbid syndromes, 1996; and Del Medico, Weller and Weller summary of a range of studies on comorbid phenomena in children, 1996), there is little research to date that follows up children diagnosed with multiple disorders and examines the implications for long-term functioning either alone or in comparison with the effects of single disorders. The current study, due to its small sample size, does not permit an in-depth look at the co-occurrence of specific disorders and their long-term sequelae. Nor does it allow for a teasing out of various combinations of co-occurring syndromes, comparing and contrasting, for example, the difference between multiple internalizing or externalizing disorders versus a combination of the two. It does, however, underscore the need for a better understanding of the phenomenon of comorbidity, not only as it relates to conceptual issues of diagnosis, but also, and no less importantly, to its long-term implications for children diagnosed with multiple disorders.

6.5.3 The effects of parental psychopathology on child development

A further point arising from the current findings relates to the relative effects of parental influences on children's long-term development. The findings of the current study paint a somewhat complicated picture. Although both Mother and Father GAF scores correlated significantly with subjects' AFI scores, neither parental psychopathology nor their global functioning emerged as significant predictors of long-term adult outcome within the current sample. Indeed, when both the global functioning and psychiatric status of child and parents were analyzed, in both cases it was the child factor alone that significantly predicted adult functioning. The relative lack of parental effect on child outcome is rather surprising given the plethora of research that underscores the influence of parental psychopathology on child development. The findings of the AFC retrospective study, for example, consistently found parental pathology to contribute significantly to the likely success of the child's treatment (Fonagy & Target, 1997). Indeed, researchers have given a great deal of attention to the long-term effects (both genetic and environmental) of growing up with parents suffering from psychiatric disorders (Fonagy et al., 2002;

Russo & Beidel, 1994). When considering the extreme dependence, both emotional and practical, that young children have on their parents and the daily, intensive exposure they have to their parents' disorders and their multiple, and often disturbing, manifestations, the current findings are somewhat unexpected. As stated earlier, these findings may be somewhat unreliable given the underpowered statistical analyses employed in the study.

Recent studies (see review by Garmezy and Masten, 1994) have broadened our understanding of the influence of parental psychopathology on children by looking at the complex interaction of both risk and protective factors and the mechanisms that underlie these processes (see Rutter, 1990). For example, studies have shown that it is not parental pathology per se, but rather its expression in terms of parental discord and neglect of children's emotional needs that put children of disordered parents at particular risk. In contrast, resilience factors, such as positive self-concept and school achievement, seem to serve as a buffer or protective mechanism against this type of risk, despite a background of parental disorder. Although heredity and environment clearly play an important role in the development of pathology (Richters & Weintraub, 1990), not all children exposed to these risk factors go on to develop psychopathology. Radke-Yarrow and colleagues (1985) discussed several protective factors that seem to affect development in a positive direction, at least in the short-term. Protective factors include intelligence, curiosity, pleasing physical appearance, socially winning ways and a match between the child's characteristics and the parents' needs.

The current findings support an interactional perspective in which children are not seen as direct and passive recipients of their parents' influences, but rather as dynamic and active players in their own development. Although parental psychopathology clearly has the potential to influence child development in negative ways, it seems that the extent of its influence depends on the way in which parental psychopathology interacts with the child's own characteristics and strengths. Although the small sample size of the study does not allow for large-scale generalizations, the findings perhaps encourage a somewhat more optimistic view of development. While recognizing the potential of a child's background, including parental functioning, to influence a child's future, the current findings support the notion that an individual's adult functioning is not necessarily 'doomed' or predetermined by his or her childhood background alone. Rather, it is the result of a complex interplay between external and internal factors (both of

which are the result of heredity and environment) that influences the way in which an individual develops over time.

6.5.4 The long-term influence of psychotherapeutic interventions

A further point relates to the extent to which psychotherapeutic interventions in childhood can serve as a mediating variable between potentially detrimental factors, both in the child and in his or her family environment, and long-term outcome. Although none of the treatment variables significantly predicted adult functioning, the current findings offer some evidence that intensive intervention in childhood is associated with both short- and long-term positive gains. Overall, the subjects who participated in the study were assessed as adequate to well-functioning adults across a range of outcome measures and on the AFI. All of the subjects who were functioning well both in DSM and HCAM terms at the end of treatment achieved AFI scores in the moderate to high range at follow-up. Moreover, many of the subjects who were not functioning well at the end of treatment in childhood (termination HCAM < 70) turned out to be well functioning adults, with the exception of the four particularly disturbed subjects described in section 6.2.1. This suggests that some of the benefits of treatment in childhood may express themselves later on in adult life. Clearly, the lack of a control group who did not receive treatment precludes the conclusion that positive adult functioning among the current sample is a direct result of psychoanalytic treatment in childhood. Moreover, there is a limitless number of variables post treatment that may have contributed to their positive adult outcome. At the same time, however, the literature overwhelmingly suggests that disordered children are at risk of developing into disordered and poorer functioning adults (see Hechtman, 1996, for example). The fact that the majority of subjects did not turn into dysfunctional adults suggests that psychoanalytic treatment may have forestalled the expected negative life trajectory for the majority of these individuals, leading to a more positive adult outcome.

In keeping with the above discussion, psychotherapeutic treatment in childhood can be perceived as a protective factor that serves to moderate the deleterious and long-term effects of parental and child psychiatric disorder on long-term development. Developmental psychopathologists refer to the phenomenon of key turning points (Rutter,

1990) or new opportunities (i.e., army recruitment, going away to school, a new job, etc.) - processes that have the potential to alter the life trajectory of a troubled individual and place them on a healthier and more positive track. Often, these experiences involve a relationship with a new and significant other (i.e., boy or girlfriend, mentor, teacher). Perhaps, an important 'ingredient' of the psychoanalytic process can be conceived of along these lines: a key turning point or new opportunity that introduces a significant individual into the patient's life. As such, the psychoanalytic process exposes the individual to a new way of relating and thinking, with the potential to alter his/her life course in a significant manner and thereby positively effect future development.

This optimistic view of the potentially positive long-term outcome of treatment in childhood requires some qualification, given that Patient HCAM at assessment was found to be the best predictor of adult outcome, even when termination variables were taken into account. One might have expected that the child's functioning or diagnostic status at the conclusion of treatment would be a better predictor of adult outcome than a pre-treatment variable. The fact that they do not raises some questions about the relative effects of treatment in childhood on adult outcome as compared to premorbid traits or abilities. The current findings demonstrate that when taking into account both pre- and post-treatment variables, the child's global pre-treatment level of psychosocial functioning predicted adult outcome better than his or her functioning post-treatment (both in terms of HCAM and DSM diagnoses). In other words there is something about a child before commencing treatment that is, perhaps, more predictive of his or her future development than how well she or he responds to treatment. It would appear that this 'something' is picked up by the HCAM measure pre-treatment and, perhaps, points to certain inherent characteristics in children that enable them to cope better with the adversities that life throws their way.

Indeed, Garmezy, in his review of research on stress-resistant children (Garmezy, 1985; Masten & Garmezy, 1985), cited three sets of variables that act as protective factors. The first set relates to personality features including autonomy, self-esteem, and a positive social orientation. Vander Stoep and colleagues (2002) referred to the construct of "premorbid competence" which includes an individual's functioning across occupational, educational and social domains before the onset of mental illness. They cited several authors who report that premorbid competence is strongly associated with

prognosis across a range of mental disorders (for example, Giaconia et al., 1994; Zigler & Phillips, 1960). Within the follow-up study, many of the subjects with poor global functioning pre-treatment turned out to be well-functioning adults. However, individuals with a particularly disturbed level of functioning in early life did not seem to derive benefit from psychoanalytic treatment in childhood. Indeed, their highly disturbed childhood state seemed to be intractable and highly resistant to the potential benefits of psychotherapeutic intervention, both in the short and long-term. The degree to which individuals benefited from psychoanalytic treatment was not commensurate with length of treatment. Interestingly, a discriminant function analysis found that subjects with lengthier childhood treatment were more likely to have a disorganized adult attachment status (unresolved on loss or abuse or cannot classify). Thus, it appears, that despite therapists' concerted and long-term effort to help these disturbed individuals, increased length of treatment did not lead to significant improvement either in the short or long-term. These findings, and the ideas discussed above, relate to questions regarding the extent to which personality and resilience are innate or environmentally influenced, changeable or enduring and, to what extent, psychotherapeutic interventions can impact pre-existing traits.

6.5.5 Treatment response, attachment and the AFI

Another area worthy of discussion concerns the possible relationship between attachment classification and treatment response. Or, in other words, the extent to which an individual's attachment style (secure or insecure) predicts one's ability to benefit from psychotherapeutic intervention. Meyer and colleagues (2001) pointed out that given that insecure attachment reflects a difficulty in relating to others, it may also undermine a patient's ability to benefit from psychotherapy due to a difficulty in relating to treatment providers. One might assume, therefore, that subjects classified as insecurely attached, regardless of type, would show less improvement as the result of psychotherapy than securely attached individuals. As mentioned above, Cyranowski and colleagues (2002) found this to be particularly true of the depressed women in their study who were classified as having a fearful avoidant attachment style. These women took the longest to recover from their symptoms in response to interpersonal psychotherapy. Although Meyer and colleagues hypothesized that insecure forms of attachment, especially the

anxious-ambivalent variant, would adversely affect symptom outcome, they did not find evidence supporting the view that the anxious-ambivalent category predicted poorest treatment outcome. Instead, they found that securely attached individuals, as assessed by Pilkonis' attachment prototypes (1988), showed greater relative improvement on a global functioning measure (GAF) and in relation to anxiety symptoms. These findings support the view that insecure attachment style predicts poorer treatment results, but do not highlight a particular form of insecure attachment as associated with poorest treatment outcome. However, in the study conducted by Fonagy and colleagues (1996) described above, a somewhat different finding was reported. Based on their preliminary findings, they suggested that individuals with an insecure rather than secure attachment style, specifically of a dismissing nature, were more likely to show improvement as a result of psychotherapy.

Interestingly, an analysis of childhood variables and adult attachment status in the current study found a similar result. Two childhood variables reflecting positive outcome as a result of psychoanalytic treatment in childhood were found to be significantly associated with a dismissing adult attachment classification. These included termination HCAM scores and the extent of change between HCAM scores assessed at intake and then again at termination of treatment. In other words, children who demonstrated higher global functioning scores and a greater degree of improvement in global functioning at the end of treatment were associated with an insecure dismissing attachment style in adulthood rather than a secure one. Additional studies that examine the relationship between attachment status and treatment outcome are required, and it is important that such studies assess attachment and global functioning both before and after the course of treatment.

Given the long-term follow-up nature of the current study, it may be that individuals with a dismissing attachment classification responded best to treatment in childhood in the immediate sense but that their gains were not necessarily maintained over time. In the current sample, dismissing individuals had significantly poorer AFI scores in adulthood, implying that despite their ability to benefit from treatment in childhood in the short-term, this improvement was not sustained into adulthood. Given that the files of the AFC did not include an attachment assessment at referral or termination, we do not know the nature of the subjects' attachment status in childhood. And it is of course possible that

their attachment patterns underwent change from termination of treatment in childhood to adulthood. Again, only prospective longitudinal studies that explore the relationship between global functioning, psychopathology and security of attachment at several points in time (in childhood before commencement of treatment, in childhood at the termination of treatment, and later perhaps in adolescence, young adulthood, and later life) can hope to elucidate the complex interplay of these variables.

6.5.6 Psychotherapeutic intervention, attachment and reflective function

The above discussion emphasized the important role of security of attachment in enabling an individual to develop into a well functioning adult. In the current sample, a secure attachment status was associated with the ability to foster and maintain supportive and intimate relationships; to plan and respond to changes and transitions across multiple life domains; to cope with the adversities that life presents and, perhaps, to prevent such adversity, including the negative influences of psychiatric disorders. Two natural questions spring to mind. The first question focuses on the processes through which attachment status is developed and maintained. Or, in other words, how does a particular attachment style come into being and what factors maintain it over time? The second question relates to the prevention of insecure attachment and ponders whether there are means by which insecure attachment can be avoided or ameliorated thereby fostering a secure attachment status. Both questions have clear implications for the field of psychotherapy and for public policy in regard to mental health.

Stein and colleagues (1998), in their comprehensive review of attachment measures, summarized several perspectives regarding the development and maintenance of attachment. According to these authors, the social cognition point of view posits that attachment status is maintained through interpersonal mediating processes in which attachment shifts from early parent-child relationships to peers and then to sexual mating through the process of proximity seeking (see, for example, Hazan and Shaver, 1994). Developmental psychopathologists, such as Carlson and Sroufe (1995), suggested a different set of processes. According to them, the interaction between an infant's biological predispositions and the caregiver's responses fosters patterns of self-regulation that maintain attachment continuity over time. A cognitive perspective, presented by

Crittenden (1995), offers yet another explanation in which the maintenance of attachment classifications is seen as the outcome of information processing patterns that differ in terms of the flexibility with which they integrate cognition and affect. Finally, Stein and colleagues presented the psychoanalytic perspective put forward by Fonagy and colleagues (1995, 1997) who view the development of secure attachment in relation to reflective capacity, the ability to mentalize productively on the psychological states of self and other, which is contingent upon the child's observations and explorations of the primary caregiver.

Fonagy and colleagues reported on the results of studies that explore the connection between attachment and reflective function. In one study, Fonagy and colleagues (1994) presented a comparison of a group of mothers who had reported significant deprivation with a group who had not. The authors predicted that mothers in the deprived group would be far more likely to have children with a secure attachment status if the mothers had high reflective function scores. The results were unequivocal. As predicted, all of the deprived mothers with high reflective function ratings had children who were securely attached. In contrast, only 1 out of 17 deprived mothers with low reflective functioning did so. These results led Fonagy to conclude that "the capacity to reflect on ideas related to attachment serves as a protective, resilience-enhancing function, reducing the likelihood of intergenerational transmission of insecurity" (Fonagy, 1997, p. 254). Similarly, in a longitudinal study of 92 children Fonagy and colleagues (1995) found that parents with high reflective functioning scores were more likely to have securely attached children.

More recently, Fonagy (2001) presented evidence for what he calls the Interpersonal Interpretive Mechanism (IIM) in a discussion of the interaction between genetic vulnerability and family environment as it relates to the development of psychopathology. IIM refers to the child's representational system wherein lies the ability to understand mental states and to differentiate between self and other (i.e., reflective function). According to Fonagy, this representational system determines whether a genetic predisposition toward mental disorder becomes expressed. The interpersonal environment between child and caregiver fosters attachment security in the first year of life; this, in turn, enables the development of interpersonal interpretation. In his view,

the terms resilience and invulnerability may best be understood in terms of the Interpersonal Interpretive Mechanism.

In keeping with the above discussion, mental health professionals should concern themselves with supporting parent-infant relationships that foster security of attachment and reflective functioning or IIM. Ideally, this should be done from as early as possible, perhaps even peri-natally, specifically among populations at risk for developing psychopathology. Fonagy (1998) underscored the need for early prevention, particularly in relation to individuals at risk for developing conduct disorder in childhood, a disorder that is resistant to treatment and often linked to delinquency and criminal behavior in adulthood (Farrington, 1995). In this view, the contributions of early parent training, the enhancement of secure attachment, and the importance of fostering reflective functioning are three important foci for infant mental health prevention programs. The findings of the current study highlight the important role of parental involvement in fostering a secure attachment status.

A discriminant function analysis found that parent guidance together with a higher number of learning difficulties distinguished the securely attached adult subjects from their insecure counterparts. Despite significant academic and, often, social impairment, subjects whose parents received parent guidance concomitant to their own childhood analysis, were more likely to become securely attached adults. In contrast, subjects with higher numbers of learning difficulties whose parents did not participate in parent guidance during their children's treatment were more likely to become insecurely attached, specifically preoccupied. It is likely that parent guidance helps parents to better understand their children and therefore to respond to them in a more empathic and coherent manner, ultimately leading to a more secure attachment status. This clearly supports the importance of parent guidance but also suggests that preventative parent training may help forestall some of the emotional complications that lead to child mental health difficulties.

To date, however, most mental health services respond to existing psychopathology rather than offering prevention through a range of therapeutic approaches. Fonagy and colleagues (1995) suggested that psychoanalytic treatment in childhood enhances the individual's mentalizing and reflective capacities, resulting in more coherent internal

representations of early attachment relationships. As such, psychoanalysis in childhood, by fostering secure attachment and reflective capacities may serve as an important mediator between childhood pathology and adult functioning. In the current study, securely attached individuals had significantly higher AFI scores that, in turn, were significantly associated with higher reflective functioning scores. Although proponents of psychoanalysis would welcome the conclusion that psychoanalytic treatment in childhood fostered reflective function, leading to security of attachment and subsequent long-term adjustment, such a statement requires too many leaps not fully supported by the current study's findings. Two primary obstacles limit such conclusions. First, there are no measures of reflective function in childhood prior to or at the conclusion of treatment. As a result, attributing improved reflective capacity to psychoanalytic treatment in childhood can be hypothesized but not proven. Second, not all of the subjects in the study received a secure attachment classification in adulthood, yet all had received psychoanalysis in childhood. Even if one could prove a direct relationship between psychoanalytic treatment in childhood and security of attachment and higher reflective functioning scores in adulthood (something the current study cannot claim to do), one would still need to explain why some of the individuals who received psychoanalysis in childhood did not become securely attached as adults or have a developed reflective capacity. One area of outcome research that may help clarify this phenomenon is the exploration of the process of psychotherapy, focusing specifically on concepts and constructs related to attachment and reflective functioning as manifested before, during and after treatment. Process measures that assess the development of reflective capacity at these three points may help to shed light on whether psychoanalytic treatment indeed enhances and improves this important capacity and whether this capacity is maintained over time.

6.5.7 The nature-nurture controversy

The fact that a child's global functioning before treatment is a better predictor of adult outcome than his or her functioning at the end of treatment in childhood raises questions regarding the 'nature-nurture' debate. In this case, nature refers to an individual's pre-existing personality or psyche whereas nurture refers to the environmental effects of psychotherapeutic intervention. Perhaps, then, the findings suggest that despite the

beneficial gains of intensive treatment in childhood, certain pre-treatment factors continue to play an influential role in how one functions later in life as an adult. That is not to say that treatment has no long-term effects, but rather that an individual's global functioning level prior to treatment may continue to influence his or her life over time, above and beyond the beneficial achievements gained as a result of treatment in childhood.

Although until recently individual differences in personality were primarily conceived of in terms of psychosocial factors (Livesley et al., 1993), recent studies have increasingly focused on the biological substrates of both normal and pathological personality traits. The results of these heritability studies overwhelmingly point to the existence of a substantial genetic basis to personality (Livesley et al., 1993; McRae & Costa, 1990; Millon & Davis, 1995; Plomin & Caspi, 1999). Although researchers do not advocate a single underlying cause to psychopathology (see, for example, Hamer & Copeland, 1998; Plomin, Owen & McGuffin, 1994), genetic predisposition may cause an individual to be more susceptible to dysfunction in response to stress (Millon & Davis, 1995). Plomin and Caspi (1999) have shown that genetics contribute not only to heritability but also to environmental influences that affect personality and disorder. The authors draw heavily from research on non-shared environmental influences that affect siblings in the same family, for example, in multiple and varied ways (Plomin, 1994; Kendler et al., 1992, Pike et al., 1996). Rutter (2002) summarized the current state of research stating that it is clear, to date, that both genetic and environmental factors exact strong and pervasive influences on development, but that neither is determinative. Although the importance of gene-environment correlations and interactions has now been recognized, a great deal remains to be understood regarding their underlying mechanisms, particularly with regard to the development of psychopathology.

The above studies indicate that genetics play an important role in shaping personality and the way in which individuals respond to their environments. Hampson (1999), in her discussion of the nature-nurture debate, concluded that while genetics and environmental influences place limits on personality, there remains room for growth and adaptation within these limitations. Caspi and Roberts (1999) reported that personality shows modest continuity from childhood to adulthood. In their words, although environmental factors continue to affect adult personality, over time, "the battle between change and

consistency is won out by the forces of continuity" (p. 319). However, the authors noted that there are still many questions that remain unanswered regarding the degree to which personality can be altered through proactive means such as psychotherapy and the ways in which these changes occur. Indeed the notion of an innate genetic personality substrate raises important questions regarding the ability to change or influence personality traits through environmental factors including psychotherapeutic intervention. In this vein, Livesley and colleagues (1993) commented on the possible implications of genetic vulnerability for treatment planning. According to them, the existence of a genetic predisposition to dysfunctional personality traits may modify the ways in which an individual responds to different types of interventions. Moreover, it may limit the degree to which significant change due to treatment is possible, particularly among adult patients.

These findings should be considered, however, within a developmental context. The subjects followed up in the current study, received psychoanalytic treatment in childhood, at a stage of life when personality is still developing (Caspi & Roberts, 1999). It is therefore possible that some of the processes underlying the subjects' overall good level of functioning in adulthood are attributable, in part, to successful and enduring change brought about through psychoanalytic treatment. However, the finding that pre-treatment global functioning levels best predict adult outcome, cautiously supports the notion that premorbid traits play an important and enduring role in development throughout childhood and into adulthood and that the influence of psychotherapeutic intervention is limited to these predetermined constraints. Psychotherapy can be seen as working primarily within the parameters of an individual's genetic and environmental boundaries (both internal and external) in order to realize the individual's inherent potential. The extent to which an individual can respond to this intervention likely depends upon a host of environmental and genetic factors (parental support, for example), whose complex interplay is yet to be understood.

The lack of a control group clearly limits the generalizability of these findings. In order to do so it would be necessary to have a control group comprised of adults who suffered from similar disorders in childhood but who did not receive therapeutic intervention, enabling a comparison of the two groups' current adult functioning. Although such a comparison would most likely allow for conclusions regarding the general influence of

therapeutic intervention in childhood on long-term adult adjustment, it would not necessarily help to untangle the complex interplay between genetics and environment, between personality and psychopathology (Widiger et al., 1999). Moreover, the precise role of therapeutic factors (environmental) versus premorbid genetic factors would be very difficult to tease out. In the current study, global functioning in childhood, prior to treatment, emerged as the most significant predictor of adult functioning, but the number of termination diagnoses explained a similar percentage of variance in AFI scores. Assuming that a decrease in diagnoses at the end of treatment is a result of the therapeutic intervention, it seems plausible that environmental influences, such as psychotherapy, also play an important role in development, alongside premorbid abilities. Plomin and Caspi (1999) asserted that the nature-nurture controversy has undergone a change. They posit that the 'either-or' approach is no longer the focus of research but rather the interplay of the two. Indeed, the current findings, in keeping with recent research, support this change in focus away from an exclusive approach to understanding human nature and behavior toward an inclusive 'nature **and** nurture' perspective. In this vein, Rutter (2002) called for increasing epidemiologic research exploring the interplay of genetics, environment and developmental processes, focusing on the multi-factorial etiology of psychopathology and resilience.

6.6 CONCLUSIONS

This chapter explores the relationship between childhood variables assessed retrospectively on the basis of the subjects' childhood case files and their current adult functioning levels as assessed by their outcome follow-up interviews. Specifically, the chapter examines childhood factors from treatment assessment and termination periods in relation to the AFI. The childhood variable most predictive of adult outcome is the assessment HCAM score, indicating that the patient's pre-treatment global functioning levels best predict long-term adaptation in adulthood. However, when termination variables are analyzed alone, the number of termination diagnoses emerges as the best predictor of long-term adult functioning. These findings support the inclusive approach of the AFI that incorporates both psychiatric symptomatology and positive adaptation into an overall global functioning score.

Although poor global functioning at assessment predicts poor adult outcome, a third of the sample went on to become well-functioning adults, despite low assessment HCAM scores. Common to these subjects is a secure adult attachment classification. In light of this finding, special attention is given to the important mediating role of attachment with regard to adult outcome. The potential effect of psychotherapy on the development of a secure attachment status is discussed, highlighting the importance of reflective functioning in this process. According to Fonagy and colleagues (1995), psychoanalytic treatment in childhood enhances the individual's mentalizing and reflective capacities, resulting in more coherent internal representations of early attachment relationships. As such, psychoanalysis in childhood may lead to more securely attached adults with an improved capacity for supportive and intimate personal relationships that, in turn, may help minimize exposure to severe life events, including psychopathology. In this vein, the chapter examines the interplay between psychoanalysis in childhood, adult attachment and reflective functioning, and their implications for helping at-risk children to develop across a more positive life trajectory. Throughout the chapter, the exploratory nature of the findings is described in light of the study's limitations, and recommendations for future research are presented. These themes are further developed in the concluding chapter.

CHAPTER 7. CONCLUSIONS AND RECOMMENDATIONS

This chapter provides a summary of the central findings of the AFC long-term follow-up study of 34 adults who received psychoanalytic treatment in childhood. The findings are discussed in light of the study's methodological and design limitations, with particular emphasis given to the issue of generalizability. Based on the findings and limitations of the follow-up study, recommendations for future outcome research are made.

7.1 THE CENTRAL FINDINGS OF THE FOLLOW-UP STUDY

The research presented in this dissertation is based on a long-term outcome study of child psychoanalysis. Thirty-four individuals who received treatment in childhood or adolescence at the Anna Freud Centre were 'caught up with' in adulthood and participated in extensive follow-up interviews. Childhood variables were assessed retrospectively based on the data recorded in their case files and adult outcome data was assessed through a battery of outcome measures. A multi-level assessment protocol covered adult symptomatology, personality functioning and impairment across a range of domains, as well as psychodynamic constructs. Five of the assessment measures were incorporated into the Adult Functioning Index (AFI) yielding a single overall functioning score based on both psychiatric disorder and psychosocial functioning. The relationship between AFI scores and other adult outcome measures were explored. So, too, childhood predictors of adult outcome were analyzed.

Epidemiological evidence strongly suggests that disordered children do not grow out of their difficulties but rather are at risk for ongoing and long-term psychological impairment, lasting beyond childhood and well into adulthood (Hechtman, 1996; Kim-Cohen et al., 2003). Despite this pessimistic prognosis, the majority of the 34 subjects who participated in the study appear to be functioning adequately, or even very well, in adulthood. Subjects reported relatively good physical health, with minimal need for medical services. In addition, very few of the subjects met criteria for either DSM Axis II personality disorders or SWAP-200 Q-score PD profiles. The prevalence rates of Axis

I psychiatric disorders were somewhat higher (62%) than the 50% rate reported by epidemiological studies (Bijl, Ravelli, & van Zessen, 1998; Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen & Kendler, 1994; Kringlen, Torgesen & Cramer, 2001). However, the psychiatric disorders reported did not lead to significant social impairment in the majority of subjects, nor to high demands on mental health services. Although half of the sample had contacted mental health professionals at some point during their adult life, contact tended to be brief. Thus, the overall picture that emerges from the sample is one of very good physical health and relatively non-severe mental health difficulties. These findings point to the possible long-term cost-effectiveness of intensive treatment in childhood.

The relatively mild nature of the sample's mental health difficulties is further supported by their scores on the full range of adult outcome measures. The mean overall personality functioning score assessed by the APFA was within the adaptive range, as were the average scores for four of the six APFA sub-scales. The two domains (work and love) that received below functional scores were just outside adaptive levels, closer to functional rather than dysfunctional levels. Additional evidence for the sample's healthy functioning is provided by their TAPI scores which indicate an active ability to plan and negotiate major transitions in adult life in three domains (education/work, personal relationships and independent living). This is a particularly important finding in light of evidence linking poor planning ability with increased adversity in adulthood (Champion et al., 1995). Indeed, the sample as a whole reported a relatively low number of recent severe life events and almost non-existent marked or moderate adversity throughout adult life across multiple domains. This relative lack of adversity can be conceived of as a protective factor given the strong link between adversity and psychopathology (Rutter, 1990, Rutter & Quinton, 1984). Moreover, when faced with stressors, the subjects demonstrated adequate coping abilities across domains, with particularly good coping in the work and friendship arenas. The fact that not all domains were characterized by equivalent coping levels lends further support to the notion that individuals do not cope uniformly in different settings (Folkman & Lazarus, 1980; Pearlin & Schooler, 1978) but rather are context-dependent.

A final set of outcome measures assessed the prevalence of secure versus insecure attachment classifications and the level of reflective functioning capacity within the

sample. These instruments were included not only as outcome measures but also as possible mediating variables affecting the long-term outcome of childhood disturbance. The findings indicate that the follow-up sample had a lower prevalence of securely attached individuals than reported in low risk samples (38% versus 68%, Van IJzendoorn and Bakersman-Kranenburg, 1996) but twice as many securely attached subjects than reported in clinical samples (38% versus 17% reported by Dozier and colleagues, 1999). In addition, the mean reflective functioning scores was just below average (4.3), with few scores in either the very low or above average ends of the spectrum.

One of the challenges facing psychotherapy research is the plethora of outcome measures and a lack of consensus among researchers and clinicians as to which measures are best suited to outcome research (Fonagy et al., 1999). In part, differences of opinion are due to the varying theoretical orientations existing in the field. In practice, the majority of outcome research focuses on symptoms and diagnoses as these are relatively straightforward to assess and many reliable and valid diagnostic measures of symptomatology exist. Beyond that, researchers opt for measures that are in keeping with their research goals or theoretical principles. The lack of a core assessment battery for assessing the long-term impact of early psychoanalytic treatment on adult outcome therefore necessitated the creation of an interview protocol consistent with the follow-up study's aims. To this end we compiled a multi-faceted set of assessment measures covering key areas of adult adjustment. These included psychopathology and use of mental health services, physical health and use of medical services, personality functioning across a range of domains, attainment of developmental tasks, quality of relationships, including attachment status, reflective functioning, coping skills, planning abilities, and stressors across adulthood.

A comprehensive assessment protocol is in keeping with recommendations for multi-level assessments (Fonagy, 1997; Hoagwood et al., 1996) and generates a wealth of information regarding each individual subject as well as the group as a whole. A contribution of the study was the creation of the Adult Functioning Index which enables many of the measures' findings to be condensed into an overall functioning score. Although global scores clearly lose important information related to specific measures, they provide a single summary score useful to outcome research. Given the tendency of psychiatric diagnoses to emphasize the pathological, at the expense of positive

functioning capacities, and the difficulty in disentangling functioning from symptomatology (Moos et al., 2002; Schrader et al., 1986), the AFI combines both pathological and adaptive data. To this end the SADS-L, SCID-II, APFA, TAPI and IOS were synthesized into the AFI. A reliability analysis of the AFI demonstrated a reasonable level of internal consistency supporting the inclusion of these measures in the index. In particular, the APFA stood out as a particularly apt measure for assessing personality functioning. So, too, the SCID-II symptom count (see section 5.3.2) contributed significantly to the AFI. Given the controversy surrounding the DSM Axis II personality disorders (Westen & Shedler, 1999a, 1999b; Nathan, 1998; Clarkin, Kernberg & Somavia, 1998), the current findings highlight the symptom count approach as a promising alternative to the assessment of personality disturbance.

The subjects' AFI scores indicate a relatively high level of functioning (mean = 72.21). Approximately two-thirds of the sample received scores above 70 and none of the subjects received scores reflecting extremely low levels of functioning (below 30). Subjects involved in long-term cohabiting relationships had significantly higher AFI scores. In addition, they experienced significantly fewer severe life events. This is in keeping with findings showing that the lack of a supportive intimate relationship and severe adversity are risk factors associated with adult psychopathology (Brown et al., 1990a, 1990b; Brown & Moran, 1994; Champion et al., 1995; Rutter, 1990). These findings are partially explained by the fact that subjects with higher AFI scores were, for the most part, securely rather than insecurely attached. Recent research in the field of attachment underscores the important role that security of attachment plays in the process of partner selection (Belsky & Cassidy, 1994; Hazan & Shaver, 1994) and in the subsequent quality of the relationship (Collins & Reed, 1990, Davis et al., 1994; McCarthy & Taylor, 1999; Mikulincer & Nachshon, 1991; Simpson et al., 1992). As such, attachment can be seen as a primary mediating factor underlying partner choice and subsequent severe life events (McCarthy & Taylor, 1999). The centrality of attachment and its important mediating role in development from a high risk prognosis to positive adult outcome received further support in the study's analysis of the childhood predictors of adult outcome.

As mentioned above, the overall performance of the follow-sample, on the full range of adult outcome measures, portrays a picture of adequate to well-functioning adults.

Despite their vulnerability to psychiatric and psychosocial impairment, based on epidemiological findings, the sample appears to have overcome the odds against them. Clearly, the data presented above represent the mean scores of the group, meaning that not all subjects were well functioning but that, on average, the follow-up group as a whole demonstrated positive functioning across domains and measures. Having assessed the subjects as a group, it was then of interest to see which factors could explain the individual differences within the group. First, the study explored the relationship between childhood variables taken from the subjects' case files and adult functioning as assessed by the AFI. Regression analyses found that, repeatedly, the best childhood predictor of adult functioning was the subjects' pre-treatment global functioning level as measured by the HCAM. In other words, the higher the child's initial level of functioning before treatment, the higher his or her functioning score was in adulthood. The importance of patient assessment HCAM was significant not only among the child and clinical variables, but also when compared to both parents' global functioning scores, and to all treatment and termination variables, including patient's termination HCAM score. However, when termination variables were analyzed alone, the number of psychiatric diagnoses present at the end of treatment in childhood inversely predicted adult outcome. Thus, the greater the number of diagnoses at the conclusion of treatment, the poorer the individual's functioning in adulthood.

The fact that measures of psychosocial functioning and psychiatric diagnosis both significantly predicted adult outcome lends support to the inclusive approach underlying the AFI that condenses information from both types of sources into an overall functioning score. Although the methodological correlation between the HCAM and the AFI is noteworthy, in that both measures are based on symptomatology and adaptation, the fact that the number of termination diagnoses also predicted long-term outcome underscores the importance of both types of measures for outcome research – either individually or in a combined form as in the AFI. These findings indeed suggest that both sources of data provide important information relevant to outcome research.

The finding that pre-treatment global functioning rather than termination global functioning or termination diagnostic status better predicted adult outcome raises questions regarding the relative long-term effects of treatment in childhood as compared to premorbid characteristics. One might have expected that a patient's functioning at the

end of treatment, when s/he hopefully is functioning at an improved level, would better predict long-term adaptation. The fact that it does not seems to indicate that there are innate qualities that are picked up by the HCAM that better predict long-term functioning. Vander Stoep and colleagues (2002) referred to this as "premorbid competence" which includes an individual's functioning across occupational, educational and social domains before the onset of illness. Indeed, several authors have reported a strong association between "premorbid competence" and psychiatric prognosis (Giaconia et al., 1994; Zigler & Phillips, 1960). The significance of pre-treatment functioning in predicting long-term outcome raises questions regarding the ability of environmental factors, including psychotherapy, to influence an individual's outcome. Recent research points to the important role of genetic and biological substrates for both normal and pathological personality development (Livesley, Jang, Jackson & Vernon, 1993; McRae & Costa, 1990; Millon & Davis, 1995; Plomin & Caspi, 1999). Thus, the existence of a genetic predisposition to dysfunctional personality traits may limit the ways in which individuals respond to treatment. Although gene-environment correlations and interactions are only beginning to receive attention, findings suggest (Harman, 1999) that not all individuals are able to benefit from therapeutic interventions to the same degree. The findings of the current study clearly support this notion.

Indeed, in keeping with the study's findings, subjects with severely impaired pre-treatment HCAM scores (41-50) remained highly dysfunctional as adults. Although it is possible that without treatment they may have become even more disturbed (Fonagy, Kaechel, Krause, Jones & Perron, 1999), they seem to illustrate the fact that intensive psychoanalytic intervention in childhood is not effective for all types of disturbance. In fact, there may be particularly disturbed levels of functioning for which therapeutic help is ineffectual. On a more optimistic note, however, the findings also suggest that many individuals are not doomed by their "premorbid competence" and appropriate intervention can help to overcome a poor prognosis.

In the current sample, despite a low pre-treatment global functioning level, about one-third of the sample disproved their poor prognosis, turning out to be well-functioning adults. Common to this particular group of subjects was a secure adult attachment status. Indeed, all but two individuals with high adult functioning levels (AFI score > 80) shared a secure attachment classification. This, in turn, was significantly correlated with lower

levels of psychopathology, fewer severe life events, stable and supportive intimate relationships, and a personality dimension of psychological health. These findings cautiously suggest that psychodynamic treatment in childhood may help to foster a secure attachment status that, in turn, serves as a protective factor leading to enhanced adult functioning. The long-term benefits of intensive treatment in childhood are also supported by the fact that seven subjects who remained 'cases' at the end of treatment, in that they maintained a termination HCAM score below 70 and/or a single termination DSM diagnosis, went on to receive AFI scores in the 70-85 range. These findings raise the possibility of a possible 'sleeper effect' in which treatment gains in childhood may express themselves later in life, although not necessarily at the conclusion of treatment in childhood. Several outcome studies of adult psychoanalysis, such as the Heidelberg study (Kordy et al., 1983), the Berlin Jungian study (Fonagy et al., 1999), the Boston follow-up study (Kantrowitz, 1993), and the Stockholm study (Sandell, Blomberg, Lazar, Carlsson, Broberg, & Schubert, 2000) reported the maintenance of treatment gains at follow-up. So, too, Heinicke's (Heinicke & Ramsey-Klee, 1986) study of children reported continued improvement between treatment termination and follow-up. What is particularly noteworthy in the current study is that treated children were followed up in adulthood, at a very different developmental stage from when they were first seen, often 20 years after the termination of treatment. For the most part, the subjects had maintained their treatment gains or continued to improve since termination. These findings, therefore, contribute a more extensive life-span perspective than studies conducted to date on the long-term adult outcome of child psychotherapy.

7.2 THE LIMITATIONS OF THE FOLLOW-UP STUDY

The AFC follow-up study offers a unique opportunity for exploring the long-term outcome of adults who received psychoanalytic treatment in childhood. To the best of our knowledge, it is the first attempt to follow-up psychoanalytically treated children into adulthood and, as such, opens an in-depth look into the lives of 34 individuals. Like most, if not all, clinical studies, the AFC long-term follow-up study has limitations and possible sources of error. These limitations are due, in part, to the unique clinical sample

from which the subjects are drawn as well as to research design and methodological difficulties inherent to follow-up outcome research.

7.2.1 Small sample size

A primary limitation of the current study is its relatively small sample size (n = 34). Psychoanalytically- and psycho-dynamically-oriented research has often relied on small subject groups (e.g. Baruch & Fearon, 2002; Muratori et al., 2002; Wallerstein, 1986). This is in part related to a psychoanalytic tradition of individual case studies (Target, 1993) and to the relatively small number of individuals who undergo psychoanalysis, particularly among children. Smaller sample sizes are also due to the lengthy psychoanalytic process, in which treatment often lasts for years, making it difficult to amass large pools of subjects completing psychoanalytic treatment at regular and frequent intervals. Indeed, the use of underpowered parametric statistics on a small sample size may have rendered unreliable some of the findings reported here. As a result, it is imperative that future outcome studies have the resources to follow-up larger groups of treated subjects. Despite the rich detail provided by in-depth analysis of small groups of individuals, the ability to generalize to the wider population of treated children is more constrained when the sample undergoing investigation is relatively small in size.

The difficulty in generalizing the current study's findings to other populations of treated children is due to several factors. First, the full retrospective sample from which the follow-up subjects were drawn is a unique population that in many ways diverges from typical child clinical samples. Although psychodynamic therapy is the most frequent form of treatment practiced in the majority of clinics (Nock, 2003), intensive and lengthy psychoanalysis is not. Moreover, the population of subjects treated at the Anna Freud Centre is atypical of most clinical samples in terms of the under-representation of lower IQ scores and socio-economic brackets and an unequal distribution of ethnic groups. This was the case for both the full retrospective and the smaller follow-up samples. Thus, the under-representation of subjects from poorer backgrounds and lower intelligence levels, and the lack of a broader range of ethnic groups, limit the generalizability of the retrospective study to the larger group of clinical samples. By definition, the small size of the follow-up sample curtails not only the distribution of childhood variables under

investigation, but also the distribution of adult outcome. As a result, the external validity of the adult outcome findings is limited for larger clinical groups, although its findings are likely relevant to similar groups of treated individuals. However, these limitations are partially balanced by the fact that the follow-up sample is drawn from a naturalistic clinical setting in which patients, for the most part, tend to present with comorbid disorders rather than single disturbances. In this sense, the follow-up sample is more similar to most clinical groups than samples typically investigated in laboratory-based outcome studies. Thus, the follow-up study offers more naturalistic observations on the adult outcome of individuals suffering from multiple disorders in childhood.

Given the small sample size of the follow-up study, it was not possible to track specific types of childhood disorders into adulthood in large numbers in order to explore the natural history of particular types or combinations of disorders. This is an important avenue for future outcome research given the significant difference in treatment outcome for externalizing and internalizing disorders (Fonagy & Target, 1994, 1996a, Target & Fonagy, 1994a, 1994b, 1994c). A larger follow-up sample size may have enabled further conclusions regarding the development of these general categories of disorders over time, (e.g. externalizing versus internalizing disorders), and possibly of specific disorders, following psychoanalytic intervention. Such findings would shed additional and important light on the life trajectories of specific childhood disturbances across the life span. However, such goals were clearly outside the scope of the follow-up study.

Interpreting the findings of a small sample size is further complicated by the problem of attrition. As mentioned, the original retrospective sample, from which the follow-up subjects were drawn, numbered 763 former patients. Although many of the patients did not meet the inclusion/exclusion criteria of the follow-up study, nor was it intended that all former patients would participate in the study (as this would have made unrealistic demands on research time and resources), the significant drop in numbers raises questions about the nature of the subjects who agreed to participate and the possible biases they inevitably introduced into the study. Attrition is a particularly thorny issue for long-term follow-up studies that need to trace former patients many years (in this case twenty years on average) after they completed treatment or last had contact with the clinic. During the passage of time, individuals move from cities and sometimes from

countries, change their surnames and some, unfortunately, die, limiting from the outset the ability to trace and contact a significant percentage of subjects.

In the current study, the problem of attrition was exacerbated by the high turnover of clinical interviewers, the majority of whom were students or volunteers. Most of the interviewers took part in the study for an average of one year, primarily on a part-time basis. Since interviewers underwent several months of lengthy and intensive training before beginning the follow-up interviews, a great deal of time was dedicated to training with less time remaining for conducting the interviews. This resulted in a significant time gap between initial postal contact with potential subjects and the actual scheduling of interview dates.

A final factor affecting the number of subjects who agreed to participate in the study was the length of the interview protocol that required, on average, three to four sessions of approximately three hours each. Clearly, many individuals found this time commitment problematic and, as mentioned, several subjects who initially agreed to participate later changed their mind because of the time required for the interviews. Moreover, many of the interviews stretched out over many months because of subjects' inability to find blocks of time, outside their work or family responsibilities, to devote to the interviews. Since subjects were only reimbursed for their travel costs, they had no financial incentive to participate in the study. This was true for the volunteer interviewers as well and it was not easy to find clinically trained interviewers able to work during unconventional hours (such as evenings and week-ends). This further slowed the pace at which interviews could be conducted. Since it is difficult to know whether, and in what way, subjects who could not be traced or declined to participate differ from those who did, generalizing the research findings is limited.

7.2.2 The lack of a control group

A salient limitation of the follow-up study is the lack of a control group, further limiting the generalizability of the study's findings. From a scientific perspective, the ideal control group for the follow-up sample would be a group of adults matched on a range of childhood variables (including family background, childhood symptoms and diagnoses,

impairment levels, etc.) who did not receive treatment in childhood. Without such a control group, it is very difficult to definitively attribute differences in outcome to the treatment under investigation. This is all the more complex in a long-term follow-up study of adults who were treated in childhood. Since children, by definition, are in the midst of growth and change, it is difficult to determine whether demonstrated change is the result of therapeutic intervention or to the passage of time and subsequent development. Moreover, without a non-treatment control group, it is difficult to know whether changes in symptomatology reflect the natural life course of a particular disorder, the introduction of a new disturbance, a change due to naturally occurring developmental growth or the positive result of treatment. However, finding a matched non-treatment control group is extremely difficult, particularly in a long-term follow-up study in which childhood data is assessed retrospectively rather than prospectively. Since non-treated individuals, by definition, do not have treatment files, finding a source of adult individuals with similar childhood disturbances and demographic backgrounds is particularly challenging.

7.2.3 Interview and assessment procedures

A third set of limitations relates to the interviewing and assessment procedures employed in the study. As mentioned, psychotherapy researchers have yet to agree on a core assessment battery. Although progress has been made for outcome research on adult psychotherapy (Evans et al., 2000; Strupp et al., 1997), there is no comparable assessment battery for child psychotherapy outcome research. As a result of this situation, the follow-up research team had to develop its own interview protocol. In keeping with the study's goals, a range of measures was assembled to cover not only symptomatology and psychiatric diagnoses, but also multiple developmental tasks and a range of functioning across several domains. The end result was a very lengthy protocol that, although streamlined after the initial pilot phase, was not particularly cost or time efficient. Extensive training was required in order for interviewers to master the complexity of the interviews. Since most were semi-structured, interviewers had to be familiar with the rating procedure as well as the interview protocol, as the quality of the subjects' answers determined the way in which the interviews proceeded. As mentioned in Chapter 4, the length of the protocol led to significant time lags and attrition rates. It

may also have turned away subjects who might otherwise have been willing to participate in a briefer interview process, thus further decreasing the sample size.

Regarding the measures themselves, in retrospect not all of them seemed particularly well suited to the follow-up study sample. For example, the individuals participating in the study turned out to have experienced little to no severe adversity across their adult life. As a result, the ALPHI measure which covers adversity in five domains starting from age 17 and going through multiple adult life phases may not have been ideally suited to this particular sample. However, the measure required extensive training on the part of the interviewers and took approximately an hour to administer. Perhaps, for middle to upper middle-class, employed, and above average intelligence samples, where adversity tends to be of lesser magnitude, a briefer scanning of lifetime adversity with a focus on recent years (as done with the LEDS) may have sufficed, with the benefit of cutting down interview and training time.

Similarly, some of the APFA sub-scales seemed somewhat inappropriate for a well-functioning sample. For example, the 'coping', 'negotiations', and 'non-specific social contacts' domains seemed to assess functioning in a more superficial way as compared to the 'love' and 'friendship' domains which seemed to pick up on more subtle and even unconscious patterns of relationships. The fact that each sub-scale is given equal weight in the overall APFA score seemed to blur the relative depth of each of the sub-scales. It is also not clear that the SWAP-200 interview provided significantly different findings than the SCID-II regarding the nature and prevalence of personality disorders within this sample. Again, this may be due to the relatively undisturbed level of personality functioning in the sample. However, incorporating both measures added significantly to the length of the protocol and the lack of distinction in findings does not necessarily justify the inclusion of both measures. Clearly, without knowing in advance the quality of the samples' adult functioning and life experiences, it is difficult to anticipate at the outset which measures will seem redundant. Despite concerted effort to cut down on the interview length, one is left with the impression that more interviewing was conducted than necessary, perhaps resulting in further attrition. Although the majority of subjects were highly compliant, some individuals became less responsive as the interview progressed, or became harder to pin down for future interview dates, and it is possible

that this affected the quality of their answers, particularly in the later stages of the interview procedure.

A final comment relates to the Impact of Stress (IOS) coping measure designed for use in the follow-up study. In keeping with the aims of the study, it was important to include a coping measure that assesses functioning and adaptive skills. As reported in Chapter 4, existing coping measures were unsatisfactory for a variety of reasons, resulting in the creation of IOS. Although the IOS was designed to assess coping abilities in different domains, the relative lack of severe adversity within the current sample meant that coping scores were often assigned to relatively minor difficulties. Thus a high coping score for different individuals did not necessarily reflect the same degree of stress or similar level of response. These differences were not accounted for in the IOS rating system and may have over-inflated some of the assigned coping scores.

7.2.4 Retrospective investigations

A final set of limitations relates to the retrospective nature of the follow-up study. As described in Chapter 4, studies that assess retroactively childhood symptomatology and functioning on the basis of case files have to contend with multiple difficulties. Since both the retrospective and follow-up studies were designed many years after the subjects' case files were recorded, therapists were completely unaware of the aims of these yet-to-be devised studies, and clinical notes could not be written down in keeping with them. For example, since analysts at the AFC did not diagnose children in terms of DSM or ICD diagnoses, files did not always have sufficient information on which to base the presence or absence of psychiatric diagnoses according to these classification systems. This resulted in uneven childhood data, particularly prevalent in the follow-up sample, and required the estimation of missing values. By definition, these are estimates rather than factual and potentially introduce some degree of error.

Moreover, because the follow-up study was conceived of many years after the subjects began treatment, it was not possible to conduct repeated measure comparisons using the same measure on multiple occasions. The ability to compare outcome on the same measure at different times or developmental stages is particularly relevant to a follow-up

study based on a life span perspective. So, for example, possible changes in attachment status or reflective functioning were not assessed before, during and after treatment but only at follow-up. As a result, certain conclusions cannot be drawn definitively. For example, based on single follow-up assessments we cannot conclusively report that treatment led to changes in attachment status. Nor can we conclude definitively that treatment gains assessed at termination were maintained into adulthood. Finally, we cannot determine conclusively that a particular change surfaced only at follow-up but not, for example during treatment or at termination, thereby supporting the presence of the 'sleeper effect' phenomenon.

Furthermore, the fact that following up patients was not part of the AFC's treatment plan, unless patients initiated contact with the Centre voluntarily, a lengthy gap exists between end of treatment in childhood or adolescence and follow-up between the ages of 25-50. Although many of the adult outcome measures are based on a life-span perspective (such as the APFA, ALPHI or TAPI), there are clearly gaps in our knowledge of the subjects' adult lives and, potentially, important post-treatment risk or protective factors may have remained unknown to the interviewers. Without more regular follow-up assessments following treatment, there may be multiple intervening variables affecting adult outcome that are untapped and uncontrolled for in a single follow-up assessment in early- to mid-adulthood.

7.3 RECOMMENDATIONS FOR FUTURE OUTCOME RESEARCH

The long-term follow-up study described in this dissertation exemplifies many of the challenges facing the field of psychotherapy outcome research. In particular, it highlights difficulties related to retrospective studies and the problems of recruiting and maintaining subjects over lengthy periods of time. Although it is unlikely that any single study can overcome the full range of methodological difficulties posed by long-term follow-up research, the findings of the AFC follow-up study highlight several important conclusions relevant to future longitudinal outcome studies. It is, perhaps, stating the obvious that in an ideal world, one without funding constraints, large-scale longitudinal studies could be conducted with far fewer obstacles and limitations. Pragmatics, however,

require that research recommendations be made in keeping with reality constraints. In light of the study's findings, the discussion that follows presents realistic and clinically meaningful recommendations, alongside suggestions for ideal psychotherapy research. This discussion focuses primarily on the need for a core assessment battery of child psychotherapy; the use of attachment instruments as measures of treatment outcome; the inclusion of treatment control groups in longitudinal research; and the need for increased resources. The section concludes with a brief discussion regarding the potential of early preventative programs to help forestall childhood psychopathology and its long-term correlates.

7.3.1 The need for a core assessment battery

Unlike adult outcome research, the field of child psychotherapy research is currently lacking a standardized and agreed upon core assessment battery (Evans, 2002; Strupp et al., 1997). As a result, research groups assess outcome using different assessment procedures. This reality hinders the ability of researchers and clinicians to make comparisons and draw conclusions across studies using multiple research instruments. The AFC follow-up study attempted to fill this gap by comprising an amalgamated interview protocol based, for the most part, on existing measures. In keeping with the study's goals, the protocol included assessments of psychiatric symptoms and diagnoses alongside a variety of measures that assess psychosocial functioning across a range of domains. Indeed, the study found that both pre-treatment global functioning as well as the number of termination psychiatric diagnoses at termination predicted long-term adult outcome. These findings support the inclusion of both types of assessments in outcome interview protocols. Although most current research tends to focus on the assessment of symptomatology, the findings of the current study suggest that it is equally important to include measures of adaptation and functioning across multiple domains. Given that this is the first time this group of measures has been used together to assess the long-term outcome of childhood treatment, it is recommended that future studies adopt the protocol in an attempt to replicate its findings.

Clearly, the protocol used in the follow-up study represents one possible outcome battery. Ideally, child psychotherapy researchers should commit resources to the development

and testing of alternative core assessment batteries based on the above principles. Organized professional bodies, on the national and international levels, are well suited to this type of venture. It is envisioned that once a core battery is devised and proven reliable and valid, researchers would be free to supplement it with additional measures of interest based on their particular theoretical orientation or in keeping with specific research questions. In the follow-up study, the APFA as well as the SCID-II symptom count stood out as particularly meaningful measures of personality functioning. The APFA provides both an overall functioning score as well as a profile across different domains, whereas the SCID-II enables classification according to the DSM PD classification system in addition to an overall PD score based on the symptom count approach. It is therefore recommended that future outcome batteries include these measures.

Based on the experience of the follow-up study, it is important that outcome batteries are 'user-friendly', primarily in relation to the length of time needed for their administration. A shorter protocol than the one used in the follow-up study is therefore recommended. This is particularly important for prospective longitudinal studies that aim to interview individuals on repeated occasions. However, in light of recommendations for multi-level assessments (see section 2.5), achieving a streamlined protocol is no small challenge. One possible suggestion, based on the current study, is the development of reliable life-span screening measures for areas such as psychopathology, personality disorders, adversity, and the like. Screening measures could enable an interviewer to determine the need for more in-depth interviewing in a particular area rather than submit all subjects to lengthy and unnecessary interviews regardless of their relevance to a particular individual. Such screening measures should help reduce interview length, improve compliance and reduce attrition rates.

7.3.2 Attachment as a measure of treatment outcome

A central finding of the current study underlined the role of secure attachment in mediating between poor global functioning in childhood and high AFI scores in adulthood. Despite the finding that low assessment HCAM scores predicted poor adult functioning, a third of the subjects overcame their poor prognosis. Common to all of

them was a secure attachment status. These findings suggest that successful psychotherapy may lead to a shift from insecure to secure attachment status that, in turn, is associated with a range of enduring positive functioning dimensions. However, in the context of the follow-up study, this could not be determined conclusively given that subjects' attachment status was assessed only at follow-up and there is no comparable information regarding their attachment status before, during or after treatment in childhood.

To date, few studies have used attachment measures as indicators of therapy-induced improvement (Erikson, Kormacher & Egeland, 1992; Fonagy et al., 1995; Juffer, van IJzendoorn, & Bakermans-Kranenburg, 1997) and the findings are not yet conclusive. The findings of the follow-up study suggest that the use of attachment measures as assessors of treatment response is a potentially exciting avenue for future research. Clearly, in order to track potential changes in attachment due to therapeutic intervention, assessment measures need to be administered on several occasions. To this end, outcome research needs to adopt a prospective longitudinal perspective in which subjects are assessed on multiple occasions. Ideally, subjects should be assessed at referral (before the onset of treatment), during the course of therapy, at termination of treatment, and at follow-up. Data from such studies will provide important information on the ways in which attachment status changes or remains stable over time in response to psychotherapy, and whether these changes are maintained over time. In addition to attachment, Fonagy (1997) and colleagues (1995) suggest that reflective functioning, or the capacity to mentalize productively on the psychological states of self and other, particularly in relation to attachment, serves as a protective, resilience-enhancing function. Moreover, they posit that successful psychotherapy fosters the capacity for reflective functioning. It is, therefore, recommended that prospective longitudinal outcome studies assess this capacity along with attachment on multiple occasions across the life span.

With regard to adult follow-up assessments, it is recommended that adult outcome be assessed on at least two occasions, once during subjects' twenties and once at age 30+. Findings from the follow-up study underscore early adulthood (ages 20-30) as an especially vulnerable developmental stage characterized by increased stressors (Reinherz, Paradis, Giaconia, Stashwick & Fitzmaurice, 2003). This is perhaps due to the lack of

committed long-term intimate relationships during this stage of life and their known protective effects. Subjects in mid-adulthood (30-40 years of age) are more likely to have established stable relationships as well as employment patterns. It is, therefore, important that long-term follow-up distinguish between these two stages of adult life. Thus, future research should take into account that adults, ranging from twenty to forty, are not necessarily representative of the same developmental stage. Using a life-span developmental perspective, in which adults are assessed both in early and mid-adulthood, should provide meaningful information regarding the unique tasks, challenges and stressors particular to different life stages and the ways in which attachment, reflective functioning and additional mediating variables interact with them.

7.3.3 The inclusion of control groups in outcome research

The results of the follow-up study also highlight the need for control groups in psychotherapy research. Ideally, in order to conclude that a particular outcome is the result of a specific intervention, one needs to compare the treated group to a non-treatment control group. However, depriving individuals in need of treatment from potentially effective interventions, in order to create a non-treatment control group, is not a viable option from an ethical perspective (Angell, 1997; Elkin, 1994; Fonagy, 2001; Lurie & Wolfe, 1997). The best solution to this dilemma is to design an outcome study in which matched subjects are randomly assigned to two or more different treatment groups. This is in keeping with the RCT methodological approach described in Chapter 2. The choice of treatment modalities can be determined by the specific focus of the research project. So, for example, psychodynamic treatments can be compared to behavioral/cognitive therapies. Alternatively, long-term versus short-term psychodynamic treatment modalities can be compared. In this way, no one is deprived of treatment, and comparisons of different therapies can be made both in terms of immediate and long-lasting treatment gains.

This type of comparison seems particularly important in light of the study's findings. In the current sample, particularly disturbed youngsters seemed unresponsive to psychoanalytic treatment in childhood, despite its lengthy and intensive nature. Finding more beneficial treatments, if they exist, would not only bring a measure of relief to

these individuals and their families, but would also minimize the misallocation of mental health resources, enabling more individuals who are responsive to such treatments to receive appropriate help. Until such comparisons are made it is impossible to know if disturbed individuals can respond positively to other forms of treatment or whether they are immune to all interventions. It is also possible that findings from comparative studies will suggest that intensive psychoanalytic treatment prevents further deterioration relative to other interventions, thus underlining the important contribution of intensive treatment to these individuals. Without such studies, however, the above possibilities remain hypothetical conjectures. It is, therefore, recommended that psychotherapy researchers conduct comparative studies whose results will better inform clinicians and public policy makers about which types of treatment are best suited to specific individuals. The current 'age of accountability' (Evans, 2000; Gabbard, 2000; Guthrie, 2000; Hoagwood, 2000; Jensen et al., 1996; Peebles, 2000; Petti, 2000; Weiss, 1998a, 1998b) and increasing consumer sophistication requires that practitioners base their treatments on firm evidence regarding the effectiveness of particular treatments for specific types and combinations of disorders. Findings based on prospective longitudinal studies that compare the short and long-term effectiveness of different treatment modalities are therefore essential.

7.3.4 Committing resources to child psychotherapy outcome research

A further, more general, recommendation relates to the need for adequate financial resources in order to carry out meaningful outcome research (see Bergin & Garfield, 1994). In the current study, the lack of resources invested in the interviewers led, among other problems, to a high rate of turnover, the need for repeated and lengthy training, and a delay in beginning and completing interviews. Reliance on part-time volunteers most definitely took a toll on the pace at which the study took place, exacerbating problems relating to attrition. It is also possible that being able to offer subjects some type of remuneration for their participation may have increased compliance rates. Taken together, these factors underscore the need to allocate increased resources to child psychotherapy outcome projects in order to facilitate longitudinal studies that provide a long-term perspective on the adult outcome of child psychotherapy interventions among meaningful sample sizes.

The issue of funding is clearly a public policy issue in terms of the extent to which governments and professional organizations are willing to commit resources to outcome research. Although the need for increased resources may well belong to the category of ideal versus realistic recommendations, one cannot conclude a discussion of the study's implications without reference to it. Organizations such as universities or therapeutic centers, with a clear commitment to clinical research, are well suited to longitudinal studies, as these require significant and stable manpower, technical support, and the infrastructure for storing archival material gathered over a period of years. However, it is, perhaps necessary that institutions such as the World Health Organization (WHO, 2003) become involved in the area of outcome research. Recently, the WHO recognized the important contribution of child and adolescent mental health to overall health. So, too, the organization acknowledged its lack of attention to children and adolescents relative to adults and the elderly. Indeed, in recognition of the lifelong consequences of untreated mental health difficulties in childhood, the WHO set up a series of meetings, bringing together child mental health professionals from all over the world. In keeping with this awareness, it seems suitable that international organizations such as the WHO devote resources to large-scale psychotherapy outcome research programs, coordinating outcome studies in multiple countries. Such investment can, perhaps, help narrow the gap between ideal and pragmatic research.

7.3.5 The potential of early prevention

Although not strictly research related, the study's findings underscore a final recommendation relevant to clinical practice. As mentioned, secure attachment was found to play an influential role mediating between maladaptive childhood experiences and well functioning adult behavior. Moreover, the study found that children with numerous learning difficulties, whose parents received parent guidance parallel to their treatment, were more likely to become securely attached adults. Taken together these findings suggest that interventions that help promote secure attachment and reflective functioning are clearly worthwhile. In particular, they highlight the importance of early preventative programs that help parents to foster secure attachment and reflective capacity in their young children (Erickson, Korfmacher, & Egeland, 1992; Fonagy, 1998). Parent guidance interventions based on these principles may help bolster

children's abilities to cope with stressors without the development of significant symptomatology or impairment, thereby reducing the need for therapeutic interventions and forestalling the negative long-term outcomes associated with early psychopathology.

7.4 CONCLUSIONS

The AFC long-term follow-up study offers a unique look at the lives of 34 adults who received psychoanalytic treatment in childhood. Moreover, it fills several primary gaps in existing outcome literature. First, the follow-up study is based on treatment provided in a naturalistic clinical setting rather than a laboratory-based research context. It also follows-up the lives of children who presented for treatment with multiple diagnoses and complex clinical pictures. This is more akin to clinical populations than subjects participating in most efficacy studies. In addition, the study provides a life-span perspective on the adult outcome of childhood disorders as well as a long-term exploration of the effects of treatment and their maintenance over time. Finally, the study contributes an interview protocol for the long-term assessment of psycho-dynamically oriented treatments.

Overall, the findings of the follow-up study support the view that intensive intervention in childhood may help a majority of high-risk individuals, with particular characteristics, to overcome a poor prognosis, leading to well-functioning adult lives. Specifically, children with average or above average intelligence, from middle to upper class socio-economic brackets, and suffering primarily but not exclusively from emotional disorders seem to have benefited most from psychoanalysis in childhood. In particular, the findings underscore the strong association between positive adult outcome and a secure attachment status. This finding supports the use of attachment measures as indicators of treatment related improvement. The study's unique and small sample size and lack of a control group clearly limit the ability to generalize the findings to other clinical populations. Longitudinal prospective studies in which subjects are randomly assigned to different treatment groups appear to be the best solution to many of the challenges inherent to long-term outcome research. Data from such studies should enhance our knowledge regarding which types of childhood interventions are best able to alleviate

disturbance and to enhance functioning in the short and long-term. Based on this information, clinicians will be better able to match appropriate forms of treatment to specific children suffering from particular types and combinations of disorders. Moreover, improved treatment in childhood should lead to decreased disturbance in adulthood, improving the quality of life for high-risk individuals and reducing the cost to providers of mental health services. The importance of prospective longitudinal outcome research, and the resources they require, should be brought to the attention of mental health professionals and public policy makers. Information based on longitudinal prospective studies can better inform their decisions, bringing relief to greater numbers of children and reducing the long-term cost of childhood disturbances to society.

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THE ADULT OUTCOME OF CHILD PSYCHOANALYSIS: A LONG-TERM FOLLOW-UP STUDY

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APPENDICES

APPENDIX 3.1. DESCRIPTION AND LIST OF THE HCAM'S 15 PARAMETERS OF FUNCTIONING

Hampstead Child Adaptation Measure

The Hampstead Child Adaptation Measures (HCAM) is a manualization for char ratings of the Child Global Assessment Scale (CGS developed by Shaffer and colleagues in 1983. It is a 100-point scale with anchor points at ten-point intervals. The manualization was influenced by Luborsky's Health-Sickness Rating Scale (Luborsky, 1962), Anna Freud's developmental lines (A. Freud. 1963), and the measure of structural change in adult patients devised by Wallerstein and colleagues (Wallerstein, 1988). It was used in the Hampstead study toe valuate the overall level of adjustment of the child at the beginning of treatment, and at termination.

Age guidelines within the manual allow it to be used for the entire age range of the Hampstead outcome sample, from 2 to 18 years. The emphasis is on pro-social behaviors. That is, rather than the child's symptomatology being emphasized, the main focus of attention is his or her level of adaptation and ability to function in appropriate ways. The child's circumstances, both biological and social, are taken into account when making an assessment. Children with physical handicaps or social disadvantages are not rated lower on this scale, provided that they are functioning as well as the 'average' child in similar circumstances. However, where a physical condition impinges on the child's psychological functioning, this does require a rating indicating impairment. Fore example, the reduced functioning of children with mental retardation or depression in response to biological or social conditions would be reflected in the score.

A description of the overall level of functioning indicated by a particular category is attached to each; in addition, case examples are provided. These are taken from the files of actual patients in the Hampstead sample and are intended to improve reliability. The cases illustrate the parameters used in making an evaluation. These parameters are:

Appropriate responsibility for the child's own body needs
Ability to work and play
Play, hobbies, interests
Frustration tolerance and impulse control
Relationships with parents
Relationships with siblings
Relations with peers outside family
Relations with adults outside family
Levels of confidence and self-esteem
Ability to cope with stress and anxiety
Prevailing mood and variability of mood
Psychosexual development
Sense of moral responsibility
Tendency to produce physical symptoms under emotional stress
Adaptability to changes in routine

The HCAM includes guidelines for weighting different parameters in particular cases. After the rater has decided on the general region of the scale in which the case seems to fall, in comparison with the case vignettes, he or she is then asked to consider general factors which may influence the choice of category for each child. These are:

Age-appropriateness
Evenness of development
Physical and other handicaps
Prosocial adaptation
Subjective distress
Chronicity and pervasiveness of maladaptive behavior
Whether psychological development is progressing

APPENDIX 4.1. THE SCHEDULE FOR AFFECTIVE DISORDERS AND SCHIZOPHRENIA (SADS-L) INTERVIEW PROTOCOL AND RATING SHEET, WITH ADDITIONAL POST-TRAUMATIC STRESS DISORDER DIAGNOSIS

SADS-L INTERVIEW

Spitzer & Endicott, 1975

Subject Number _____

Sex 1- Male 2 - Female

Date of Interview _____

Interviewer _____

Rater _____

HOME ENVIRONMENT

On own in non-institutional setting	0	____
With spouse with or without children in shared household	1	
Household shared with parents	2	
Household shared with siblings or other non-lineal relatives	3	
Household shared with friends or other non-relatives	4	
Hostel or sheltered facility	5	
Residential treatment facility	6	

CURRENT MARITAL STATUS

Never married	0	____
Married	1	
Separated; not cohabiting	2	
Divorced; not cohabiting	3	
Widowed; not cohabiting	4	
Remarried or cohabiting	5	
Common law (at least 6 months)	6	
Homosexual partnership/other	7	

ENJOYMENT OF WORK

Not working, no interest	0	___
Not working, would like to do so	1	
Working, dislikes the job	2	
Working, neutral attitude, something to do	3	
Working, enjoys on the whole	4	
Working, positive enjoyment and involvement	5	

OCCUPATION OF CHIEF WAGE EARNER
(Using Registrar General's Classification) ___

SOCIAL CLASS OF CHIEF WAGE EARNER

Social class I	1	___
II	2	
III(N)	3	
III(M)	4	
IV	5	
V	6	

SOCIAL CLASS OF SUBJECT

Social class I	1	___
II	2	
III(N)	3	
III(M)	4	
IV	5	
V	6	

SOCIAL CLASS OF SPOUSE

Social class I	1	___
II	2	
III(N)	3	
III(M)	4	
IV	5	
V	6	

Unemployed = code last job
Housewife = 0
Student = 7
Retired = code for last substantive job

PRESENT OCCUPATION

Are you working at the moment?

IF YES: **What is your job?**

ESTABLISH AMOUNT OF TRAINING AND DEGREE OF RESPONSIBILITY:
EG. NUMBER OF PEOPLE IN CHARGE OF

Do you enjoy the job? Is it important to you?

CHIEF WAGE EARNER

Who is the main wage earner at home?

IF NOT THE SUBJECT: **What does he/she do?**

MEMBERS OF HOUSEHOLD

Who do you live with?

Who is there in your family?

MARITAL STATUS

Are you married, or ever been married?

(How old is he/she?)

CHILDREN

Do you have any children?

IF NO, GO TO PAGE....

Are all the children your own and your husband's/wife's?

IF DOUBTFUL: **Are any of them from previous marriages/relationships?**

Or any of them fostered or adopted?

Or children of relatives or friends?

Are all your children still living with you?

Where do the others live now?

Are there any other children living here with you?

Such as grandchildren? Or children of other relatives?

HOUSEHOLD

A household is a group sharing the same dwelling and regularly taking their main meal together. Rate children as part of the household if they have been there for the predominant part of the last three months. Include also (a) infants new born to the parent or to other adults in her household ; (b) children temporarily away but expected to return. Eg. children away at school or in care. This is usually evidenced by a bed being retained for them.

To rate as in the parent's household the children need not be under her care, eg. a daughter's children would count even if the daughter were caring for them. However, the rating of pairs of biological parents includes children in the household under her care only. For example, if the mother had children by two men this would count as two pairs. if she were also caring for her daughter's child this would count as an additional pair. Fostered and adopted children count for separate pairs of parents even if they are biologically related.

Code 9 if rating not known through lack of information

	NAME	AGE	NOTE PARENTAGE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

NUMBER OF MALE CHILDREN	____
NUMBER OF FEMALE CHILDREN	____
NUMBER OF CHILDREN - SEX UNKNOWN	____
TOTAL NO.OF CHILDREN BORN TO SUBJECT	____
NO.OF CHILDREN IN PARENT'S HOUSEHOLD	
Under 5	____
Under 18	____
NUMBER OF PAIRS OF BIOLOGICAL PARENTS	
Rate number of different pairs of biological parents for all children in mother's household and under her care.	____
NO.OF CHILDREN CARED FOR SHORT-TERM BUT NOT IN HOUSEHOLD	____

CARE OF THE CHILDREN

Who looks after the children most of the time?

What does that entail?

IF SUBJECT DOES MORE THAN 50% OF CARETAKING:
Do you have any support with this?
Who helps you? What does he/she do?
How much of the time is he/she responsible for ....?

Is that someone you can rely upon? What help have you had from him/her this week?

ALTERNATIVE CARETAKING

Have any of your children ever been looked after by other adults for more than a day or two?

IF YES: **When was that? What was the reason?**

Who did he/she/they stay with? How long for? How was it arranged?

ESTABLISH TOTAL NUMBER, DURATION, AND NATURE OF ARRANGEMENTS FOR ALTERNATIVE CARE.

IF NOT ALREADY CLEAR: **Have any of the children been in care or with foster parents?**

IF YES: **When was that? What was the reason?**
What kind of care order was he/she on? How long for?
What is the present position?

CARE OF THE CHILDREN
This is a rating of the extent to which the subject is responsible for the child(ren). The subject is considered responsible for the child when he/she is at nursery or school unless a family member, au pair, or similar person has undertaken to be available during that time.

ALTERNATIVE CARETAKING ARRANGEMENTS
Holidays with other adults and boarding school rate '1' unless there is also evidence that difficulties in handling the child(ren) contributed to the arrangement. Rate '2' where that is the case, or where some aspects of alternative caretaking were unsatisfactory. For instance, the caretaker had a job and the child had to be left unsupervised for a period each day. Rate '3' where the arrangements were clearly inadequate. For instance, the alternative caretaker was known to be unfit to look after children, or did not have enough room for a child in the house/flat. The time periods to be rated are of total time in care. Where there is more than one child rate for the child who has experienced the most unsatisfactory caretaking arrangement, or the longest in care.

CARE OF CHILDREN UNDER AGE 11

Subject less than 50%	0	16 - 20 ____
Equal sharing	1	21 - 30 ____
Subject, majority. Significant sharing with reliable other.	2	31 - 35 ____
Subject, majority. Some reliable sharing.	3	
Subject, majority. Some unreliable sharing.	4	
Subject does all.	5	

ALTERNATIVE CARETAKING (ever)

None.	0	____
Adequate arrangements.	1	
Dubious arrangements.	2	
Inadequate arrangements.	3	
In care, 1/12.	4	
In care, 1/12-6/12	5	
In care, >6/12	6	

PHYSICAL HEALTH

I'd like to ask you about your physical health.

Have you ever had any problems with your health?

For example, have you ever had to see you GP regularly?

For something like - regular prescriptions?
- or, blood pressure?
- or for anything else?

IF YES, RECORD - ONSET,
- DURATION,
- DIAGNOSIS (WHAT THE DR. SAID)
- AND RESULT (TREATMENT AND HANDICAP).

Have you ever been to hospital, or a clinic, as an outpatient or to stay overnight?

For any operations?
Or chest or heart problems?
Or for accidents like head injuries or broken bones?

(IF YES, GET THE DETAILS)

ONSET (AGE)	REASON	TREATMENT	RESULT/HANDICAP

PHYSICAL HEALTH

Note: To rate as a regular visitor (ever) the subject must have attended (or beenattended on) at least 3 occasions over 6 months.

VISITS TO GP (ever)			
None	=	0	___
Occasional visits for minor ailments or routine care	=	1	
Regular visits for prescription and/or physical disorder	=	2	
OUTPATIENT ATTENDANCE (EVER)			
None	=	0	___
One or two	=	1	
Three or more	=	2	
HOSPITAL ADMISSIONS (EVER)			
None	=	0	___
For childbirth or minor surgery	=	1	
Other hospital admission	=	2	
TOTAL NO. OF ADMISSIONS (for physical illness)			___ ___
PHYSICAL HANDICAP (PRESENT)			
None	=	0	___
Minor problem	=	1	
Persistent or recurrent problem that interferes with or impairs social and/or work activity for >1 month	=	2	
Persistent or recurrent problem that has resulted in cessation of normal activities and/or major change in everyday activities for >1 month	=	3	
PHYSICAL HANDICAP (PAST) Code as above, for the most severe period lasting as long as one month.			___
PHYSICAL HANDICAP - ONSET AGE (rate if 2 or 3 only)			___ ___
PHYSICAL HANDICAP - DURATION (months) (rate if 2 or 3 only total all episodes)			___ ___
PHYSICAL HANDICAP - NO OF EPISODES (rate if 2 or 3 only)			___

Code 8 when not applicable and 9 when not known

BRIQUETS/SOMATIZATION DISORDER SECTION

The essential features are recurrent and multiple somatic complaints of several years duration that, in the judgement of the interviewer, ARE NOT ADEQUATELY EXPLAINED BY PHYSICAL DISORDER AND ARE NOT SIDE EFFECTS OF MEDICATION.

The interviewer need not be convinced that the symptom was actually present, report of the symptom by the individual is sufficient.

Since mild depressive and anxiety symptoms are so ubiquitous in this disorder, you should rate physical symptoms positive when accompanied by these complaints.

So overall, how would you describe your general health?

RECORD SPONTANEOUS COMMENTS

IF REPORTS ILL HEALTH:

How long have you been poorly for? For how much of that time have you been poorly?

Would you say that you had been poorly for most of your life?

I'm now going to run through a list of symptoms,

I'd like you to tell me if you've had any of these .....

FOR EACH PROBE THAT IS AFFIRMED BY THE SUBJECT:

1.PROBE FOR PHYSICAL BASIS. IF PHYSICAL BASIS IS SYMPTOM MORE THAN EXPECTED?

2.IF "UNCERTAIN" OR "DEFINITE" SOMATIZATION SYMPTOMS GET DETAILS, RECORD AGE OF ONSET, MEDICAL CONTACT. E.G. "WHAT DID YOU DO ABOUT IT? DID YOU MENTION IT TO THE DOCTOR? WHAT DID HE SAY? HOW DID IT AFFECT YOU?

NOTE:"ALTERATION OF LIFE PATTERN" IS A SUBSTANTIAL ALTERATION. E.G. TAKING TO BED, STOPPING COOKING, REDUCED FREQUENCY OF GOING OUT ETC.

BRIQUET'S/SOMATIZATION DISORDER

SUBJECTIVE SICKNESS FOR MOST OF LIFE
(rate on the subject's reply to the probe)

No = 0 Probable = 1 Definite = 2 ____

SOMATIC SYMPTOM CHECKLIST

SYMPTOM CODING

0 = Negative reply to probe

1 = Uncertain. E.g: The interviewer feels that the symptom may have a psychological basis but cannot rule out a physical disorder.

2 = Definite. The interviewer is confident that the symptom is not explained by physical disorder (fr some symptoms it may be necessary to obtain corroborative evidence, for example, medical notes).

6 = Occurred only during another major psychiatric disorder.

7 = Questioning shows that the symptom was due to physical disorder.

CONVERSION OR PSEUDONEUROLOGICAL SYMPTOMS (DSM IV-One needed, RDC-One needed)

Have you ever had difficulty swallowing?

Or lost your voice and been unable even to whisper (but not just hoarseness)?

Have you ever lost your hearing?

Double vision?

Blurred vision?

Or have you ever lost your sight and couldn't see?

Fainting or loss of consciousness when you could not remember what had happened? (not associated with alcohol or drugs)

Memory loss?

Seizures or convulsions?

Trouble walking?

Paralysis or muscle weakness?

Difficulties passing water?

GASTROINTESTINAL SYMPTOMS (DSM IV-Two needed,RDC-One needed)

Have you had a problem with.....

Stomach pains?

Feeling that you want to be sick?

Vomiting spells (other than during pregnancy?)

Bloating of your stomach?

Feeling sick with a variety of foods?

Diarrhoea?

SYMPTOM	SYMPTOM CODING	AGE ONSET	MENTIONED PHYSICIAN (NO=0 YES=1)	TOOK ATION (NO=0 YES=1)	ALTERATION PATTERN (NO=0 YES=1)	DURATIONOF
DIFFICULLTY SWALLOWING:	___	___	___	___	___	___
VOICE LOST:	___	___	___	___	___	___
DEAFNESS:	___	___	___	___	___	___
BLURRED VISION:	___	___	___	___	___	___
BLINDNESS:	___	___	___	___	___	___
LOSS OF CONSCIOUSNESS:	___	___	___	___	___	___
MEMORY LOSS:	___	___	___	___	___	___
SEIZURES:	___	___	___	___	___	___
TROUBLE WALKING:	___	___	___	___	___	___
PARALYSIS OR WEAKNESS:	___	___	___	___	___	___
URINARY RETENTION/ DIFFICULTIES:	___	___	___	___	___	___
ABDOMINAL PAIN:	___	___	___	___	___	___
NAUSEA:	___	___	___	___	___	___
VOMITING:	___	___	___	___	___	___
BLOATING:	___	___	___	___	___	___
FOOD INTOLERANCE:	___	___	___	___	___	___
DIARRHOEA:	___	___	___	___	___	___

PAIN (DSM IV-FOUR NEEDED, RDC-ONE NEEDED)

Have you ever had a problem with painful conditions like:

pain in the back,

or in the joints,

or in your arms or legs,

or having a lot of headaches,

or pain on passing water,

or genital pain (not during intercourse)

or other sorts of pain?

CARDIOPULMONARY (DSM IV-NONE NEEDED,RDC-NONE NEEDED)

Have you ever had problems with shortness of breath,

palpitations,

chest pains,

dizziness?

RATER'S JUDGEMENT OF DRAMATIC OR COMPLICATED OR VAGUE MEDICAL HISTORY
(rate on physical health and Briquet's section)

SOMATIZATION LED TO RDC SOCIAL IMPAIRMENT OR INCAPACITATION

AGE OF ONSET OF FIRST SYMPTOM

AGE WHEN FIRST MET RDC CRITERIA

BRIQUET'S/SOMATIZATION DISORDER

SYMPTOM OF	SYMPTOM CODING	AGE OF ONSET	MENTIONED TO PHYSICIAN (NO=0 YES=1)	TOOK MEDICATION (NO=0 YES=1)	ALTERATION LIFE-PATTERN (NO=0 YES=1)	DURATION
BACK PAIN:	___	___	___	___	___	___
JOINT PAIN:	[ ]	[ ]	[ ]	[ ]	[ ]	
PAIN IN THE EXTREMITIES:	[ ]	[ ]	[ ]	[ ]	[ ]	
HEADACHES:	[ ]	[ ]	[ ]	[ ]	[ ]	
URINARY PAIN:	[ ]	[ ]	[ ]	[ ]	[ ]	
GENITAL PAIN:	[ ]	[ ]	[ ]	[ ]	[ ]	
OTHER PAIN:	[ ]	[ ]	[ ]	[ ]	[ ]	
SHORTNESS OF BREATH:	[ ]	[ ]	[ ]	[ ]	[ ]	
PALPITATIONS:	[ ]	[ ]	[ ]	[ ]	[ ]	
CHEST PAIN:	[ ]	[ ]	[ ]	[ ]	[ ]	
DIZZINESS:	[ ]	[ ]	[ ]	[ ]	[ ]	

DRAMATIC, COMPLICATED OR VAGUE MEDICAL HISTORY

No = 0 Uncertain = 1 Yes = 2 [ ]

SOMATIZATION LED TO RDC SOCIAL IMPAIRMENT OR INCAPACITATION
(Rate yes if the symptoms, alteration of routine or treatment have led to impairment/incapacitation)

No = 0 Uncertain = 1 Yes = 2 [ ]

AGE AT ONSET OF FIRST SYMPTOM (Years) [ ]

AGE WHEN FIRST MET RDC CRITERIA (Years) [ ]

HABITS

SMOKING

Do you smoke?

IF NO: **Did you ever smoke?**
(IF YES: **When did you stop? Why?)**

What do/did you smoke?

How much do/did you smoke?

DRINKING (concentrate on the most severe period)

Do you drink, alcohol I Mean?

IF NO: **Did you ever drink?**
(IF YES:**When did you stop? Why?)**

How often do/did you drink in a typical week?
(get details of frequency, amount, type of drink)

Have you ever drunk more than that?

How many drinks would you have in a typical day when you are/were drinking?

At what time of day do/did you start drinking?

How often would you have too much to drink, or get a hangover?

Do/did you ever drink on your own?
(when? How often?)

Do/did you ever drink to help you face up to things?
(when? How often?)

Has anyone ever objected to your drinking?
(When? How often?)

Have you ever felt you should cut down on your drinking?
(when? How often? What did you do?)

Did you think you were drinking too much?

Did you think it was harming your socially or affecting your moods in any way?

IF THE SUBJECT SCORES A MAXIMUM ON ANY OF THE SCREENS, OR YOU SUSPECT ALCOHOL RELATED PROBLEMS OR DEPENDENCE, COMPLETE THE SECTION.

IF NOT, go to OVERVIEW, p.

EVER SMOKED
No = 0 Yes = 1 ____
No = 9 or less cigarettes per week: Yes= 10 or more cigarettes per week

AVERAGE AMOUNT CURRENTLY/EVER SMOKED
No. of cigarettes per day ____

Ounces of tobacco per day ____

ALCOHOL SCREENS
Drink= 1 pint of beer;2 small glasses of wine; a double of spirits; 2 glasses of sherry

AVERAGE AMOUNT CONSUMED IN A TYPICAL WEEK

None other than rarely	=	0	____
Two or less drinks daily for four or more days per week	=	1	
Three or more drinks daily for four or more days	=	2	

MORNING DRINKING

None	=	0	____
Lunchtime only, or socially	=	1	
Drinks before lunch, this is not at social occasions, occurs two or more times a month	=	2	

HANGOVER/DRUNK

No, other than rarely	=	0	____
Three or more times per year, but less than weekly	=	1	
At least once per week	=	2	

SOLITARY DRINKING
Solitary=drinks alone two or more times a month
Do not rate if this occurred in exceptional circumstances.
No = 0 Uncertain = 1 Yes = 2 ____

DRINKS TO FACE UP TO THINGS
No = 0 Uncertain = 1 Yes = 2 ____

OTHER PEOPLE OBJECTED
No = 0 Uncertain = 1 Yes = 2 ____

FELT SHOULD CUT DOWN
No = 0 Uncertain = 1 Yes = 2 ____

FELT DRINKING TOO MUCH
No = 0 Uncertain = 1 Yes = 2 ____

HARMING SOCIALLY
No = 0 Uncertain = 1 Yes = 2 ____

HARMING PSYCHOLOGICALLY
No = 0 Uncertain = 1 Yes = 2 ____

ALCOHOL SECTION

ALCOHOL DEPENDENCE AND DISABILITIES

Have you found that you have to drink more and more to get the same effect?

Did/do you find that if you stop drinking or cut down that you experience: .....tremors?
..... sweating?
..... nausea or retching?

(Did/do you drink to relieve these symptoms?)

Did/do you drink in the mornings?

Have you ever tried to cut down your drinking or to stop completely?
(Did you return to the amount you were drinking before, how quickly?)

Have you ever missed work because of your drinking, or been unable to take care of things at home?

Did you ever lose your job because of your drinking? .... or have to go to hospital?

Did you ever have difficulties with your family or friends because of drinking?

Were you ever divorced or separated mainly because of your drinking?

Have you ever got into fights when you have been drinking?

Have you ever gone on a bender where you drank steadily for 2 days or more?
(How often has that happened?)

Have you ever had any motor car accidents or trouble with the traffic police when you have been drinking?

Have you ever been arrested by the police when you have been drinking? (What for?)

Have you ever been drunk on non-beverage drinks (like turps, shaving lotion) when you didn't have wine, beer or spirits to drink?

ALCOHOL DEPENDENCE AND DISABILITIES

TOLERANCE
No = 0 Uncertain = 1 Yes = 2 ____

REPEATED WITHDRAWAL SYMPTOMS
No = 0 Uncertain = 1 Yes = 2 ____

RELIEF DRINKING
No = 0 Uncertain = 1 Yes = 2 ____

EARLY MORNING DRINKING
NB This should occur around breakfast time, or an hour or two before or after.
No = 0 Uncertain = 1 Yes = 2 ____

REINSTATEMENT AFTER ABSTINENCE
No = 0 Uncertain = 1 Yes = 2 ____

ROLE IMPAIRMENT DUE TO DRINKING
NB. Rate impairment and disruption as in the main interview.
No = 0 Uncertain = 1 Yes = 2 ____

ROLE DISRUPTION DUE TO DRINKING
No = 0 Uncertain = 1 Yes = 2 ____

DIFFICULTIES IN RELATIONSHIPS DUE TO DRINKING
No = 0 Uncertain = 1 Yes = 2 ____

DIVORCED/SEPARATED DUE TO DRINKING
No = 0 Uncertain = 1 Yes = 2 ____

PHYSICAL VIOLENCE (at least twice)
No = 0 Uncertain = 1 Yes = 2 ____

BENDERS (at least twice)
NB.to rate as "Yes" a bender must be associated
with default in usual obligations for 2 days.
No = 0 Uncertain = 1 Yes = 2 ____

ACCIDENTS/OFFENCES WHEN DRINKING & DRIVING
No = 0 Uncertain = 1 Yes = 2 ____

ALCOHOL RELATED OFFENCES
No = 0 Uncertain = 1 Yes = 2 ____

USE OF NON BEVERAGE ALCOHOL
No = 0 Uncertain = 1 Yes = 2 ____

For all items on this page Code 8 when not applicable and 9 when not known.

ALCOHOL-MEDICAL COMPLICATIONS

Have you ever had blackouts? How much were you drinking then? (so that you couldn't remember what happened even though you were conscious at the time)

Have you ever had a seizure or a funny turn during or after drinking? (probe to establish there was a fit: eg. an observer said there was convulsions, cyanosis, incontinence)

Have you ever had any physical problems that might be due to drinking? (for example, have you ever had troubles with your stomach, like pain or being sick, or liver problems?)

(Has a doctor ever told you that you had neuritis, gastritis, or liver problems due to drink?)
(Did you stop drinking because of what he said?)

Have you ever had any strange episodes when you stopped drinking and you felt confused, and felt your imagination was playing tricks on you? (get details)

Have you ever had any strange experiences whilst drinking, like seeing or hearing things that were really not there? (get details or relationship of hallucinations to onset and course of alcohol problems)

Whilst you were drinking did you have any odd ideas that other people might not understand? (get details of relationship of delusions to onset and course of alcohol problems)

OTHER CHARACTERISTICS OF ALCOHOL PROBLEMS

How old were you when you first started to drink heavily?

How old were you when the problems we just talked about started?

When did you stop drinking? (not applicable if drinking heavily within the past 6 months)

Are you drinking at the moment? How much? (probe last 6 months)

PERIODS OF HEAVY DRINKING

How many times have there been where you were drinking heavily. When?

(ENSURE A PATTERN OF DRINKING AT DIFFERENT TIMES IS OBTAINED)

ALCOHOL DEPENDENCE

ALCOHOL BLACKOUTS
Blackout=memory loss for events that occurred while conscious during a time drinking.
Ensure not related to head injury.
No = 0 Suspected = 1 Definite = 2 ____

ALCOHOL RELATED FITS
No = 0 Suspected = 1 Definite = 2 ____

GASTRITIS/PEPTIC ULCERATION
Note:these physical complications of alcoholism should only
be rated as definite if the subject was told this by a doctor.
No = 0 Suspected = 1 Definite = 2 ____

NEUROPATHY
No = 0 Suspected = 1 Definite = 2 ____

LIVER DISORDER
No = 0 Suspected = 1 Definite = 2 ____

OTHER PHYSICAL COMPLICATION
No = 0 Suspected = 1 Definite = 2 ____

DRINKS DESPITE PHYSICAL DISORDER
No = 0 Suspected = 1 Definite = 2 ____

CHRONIC ORGANIC BRAIN SYNDROME
Note:rate 1 or 2 on the basis of current mini-mental state
No = 0 Suspected = 1 Definite = 2 ____

DELIRIUM TREMENS
No = 0 Suspected = 1 Definite = 2 ____

ALCOHOL RELATED HALLUCINATIONS
Note: to rate as alcohol related, hallucinations or delusions should occur
during or immediately after heavy drinking
No = 0 Suspected = 1 Definite = 2 ____

ALCOHOL RELATED DELUSIONS
No = 0 Suspected = 1 Definite = 2 ____

AGE STARTED EXCESSIVE DRINKING (Years) _____

AGE FIRST MET CRITERIA _____

AGE STOPPED (88 if heavy drinking in last 6 months) _____

EPISODE FOLLOWED BY REMISSION (of 6 months)
No = 0 Yes = 1 ____

ONE MONTH PERIOD OF HEAVY DRINKING
No = 0 Yes = 1 ____

CURRENT ALCOHOL PROBLEM (last 6/12 months)
No = 0 Yes = 1 ____

OVERVIEW OF PSYCHIATRIC DISTURBANCE: PROFESSIONAL CONTACT

Have you ever seen anyone for a nervous or emotional problem?
ENCOURAGE A SPONTANEOUS ACCOUNT

Have you ever seen your GP or a psychiatrist about your nerves?

How many times have you seen your GP/Psychiatrist about your nerves?

AT THIS POINT YOU SHOULD RECORD THE DATE OF ONSET, THE NUMBER OF EPISODES AND PERIODS OF TREATMENT, AND THE CHARACTERISTICS OF THE SYMPTOMATOLOGY. MAKE NOTES, AND ONCE YOU HAVE ESTABLISHED CHRONOLOGY AND THE SYMPTOM PATTERN, MOVE TO THE APPROPRIATE DIAGNOSTIC CATEGORIES. GET THE DETAILS OF NAMES OF THE HOSPITALS, AND ASK THE SUBJECT IF YOU MAY SPEAK TO HIS/HER DOCTOR ABOUT THE EPISODE (WHERE APPROPRIATE).

IF NO PROFESSIONAL CONTACT, GO TO UNTREATED PSYCHOPATHOLOGY, PAGE

OVERVIEW OF PSYCHIATRIC DISTURBANCE:PROFESSIONAL CONTACT

ANY PROFESSIONAL CONTACT
(Eg:GP,Social Worker, Psychiatrist)

No = 0
Yes = 1 ____

TYPE OF PROFESSIONAL CONTACT
(Rate highest)

None = 0 ____

GP, social worker, or any other NON mental health professional = 1

Mental Health Professional (eg; psychiatrist, psychologist; community psychiatric nurse) = 2

NUMBER OF EPISODES OF PSYCHIATRIC DISORDER IN WHICH THERE WAS PROFESSIONAL (any type) CONTACT ____

PROFESSIONAL CONTACT

How old were you when you first went for help, either to your GP or a psychiatrist?

How old were you when you first saw a psychiatrist/psychologist?

DETERMINE THE AMOUNT OF OUTPATIENT CONTACT (EITHER FROM HOSPITAL, GP, OR OTHER SOURCE) INCLUDING BRIEF SPELLS OF DRUG TREATMENT.

How old were you when you last saw someone about you nerves?
(GP or mental health professional)

HOSPITAL CARE

Were you ever in hospital overnight for a psychiatric problem?

How old were you when you first went into hospital?

How many times?

How old were you when you last went?

DETERMINE THE TOTAL TIME OF PSYCHIATRIC HOSPITALIZATION

TOTAL INCAPACITATION TIME DUE TO PSYCHIATRIC DISORDER

(This rating should be made after the interview has been completed, on the data gathered from the disorder sections and the psychosocial functioning interview).

AGE AT FIRST PROFESSIONAL CONTACT ___ ___
Rate any type of professional contact

AGE AT FIRST CONTACT WITH MENTAL HEALTH PROFESSIONAL ___ ___

AMOUNT OF PROFESSIONAL CONTACT (any type)

No contact	=	0	Rate here the total amount of time spent at hospitals out-patients,GP,social worker etc., having medication counselling etc.
Consultation or brief period of treatment.	=	1	
Treatment for a total time 1 year or less.	=	2	
Treatment for a total time >1 year	=	3	

___

AGE AT LAST PROFESSIONAL CONTACT ___ ___
(Rate any type of professional contact)

AGE AT FIRST HOSPITALIZATION (88 if never) ___ ___

NUMBER OF PSYCHIATRIC HOSPITALIZATIONS ___ ___

AGE AT LAST HOSPITALIZATION ___ ___

TOTAL HOSPITALIZATION TIME ___

Never	=	0
Less than 5 days	=	1
6 days to 3 months	=	2
>3 months to 6 months	=	3
>6 months to 1 year	=	4
>1 year to 2 years	=	5
>2 years to 5 years	=	6
More than 5 years	=	7

TOTAL INCAPACITATION TIME ___
(total hospitalization time + total time of principal social role incapacitation)

Never	=	0
Less than 5 days	=	1
6 days to 3 months	=	2
>3 months to 6 months	=	3
>6 months to 1 year	=	4
>1 year to 2 years	=	5
>2 years to 5 years	=	6
More than 5 years	=	7

Code 8 when not applicable and 9 when not known

UNTREATED PSYCHOPATHOLOGY

Was there ever a time when you or someone else felt that you needed help because of your feelings or nerves, but you didn't go to see someone?

(How old were you when you first felt like that?)

(How long did it last? How many times have you felt like that?)

(What sort of complaints did you have?)

UNTREATED PSYCHOPATHOLOGY

AGE AT ONSET
(Years) ____ ____

DURATION IN WEEKS
(Total of all untreated episodes) ____ ____

NUMBER OF EPISODES ____ ____

MEDICATIONS

Have you ever taken any sleeping tablets, traanquillizers, drugs that have changed your mood, or drugs to lose weight?

For example, drugs like Valium, Ativan, Prozac, Paroxetene, Tryptizol, or Largactil?

Or injections?

And what about in the last three months?

LIST DRUG NAMES, AGE FIRST AND LAST TAKEN, REASON, AND AMOUNT.

DRUG NAME	AGE FIRST	AGE LAST	REASON	AMOUNT

MEDICATIONS

	EVER No = 0 Yes = 1	AGE FIRST	LAST THREE WEKS No = 0 Yes = 1
Sleeping Tablets (Mogadon, Temazepam)	___	___ ___	___
Sedatives (Valium, Ativan)	___	___ ___	___
Stimulants for Weight Reduction (Amphetamine)	___	___ ___	___
Major Tranquillizers (Largactil, Orap, Melleril, Modecate)	___	___ ___	___
Antidepressants (Prozac, Seroxat, Prothiaden, Tryptizol, Clomipramine)	___	___ ___	___
Lithium (Priadel)	___	___ ___	___

START OF SYMPTOM SCREENING AND PSYCHIATRIC SECTIONS

IF THE SUBJECT DENIED PROFESSIONAL CONTACT/UNTREATED PSYCHOPATHOLOGY

I would just like to check about some symptoms that people sometimes get.

IF PREVIOUS PROFESSIONAL CONTACT/UNTREATED PSYCHOPATHOLOGY

I'd now like to go into a bit more detail about the trouble that you mentioned.

GO TO RELEVANT SECTION/SECTIONS

SOCIAL IMPAIRMENT AND INCAPACITATION

To establish the degree of social impairment it is important to find out the principal social role of the subject at the time of illness. For example: at work, housewife, student, at school. Impairment and incapacitation will usually refer to disturbance of this role, but you may rate impairment in other aspects of social functioning if this is marked. Note: where subjects have more than one disorder during the same episode (e.g. depression and panics) code impairment for the episode under both disorders.

SOCIAL IMPAIRMENT: refers to a decrease in the quality and/or quantity of role performance that does not amount to lengthy incapacitation. Social impairment includes:

I: CESSATION OF PRINCIPAL ROLE FUNCTIONING FOR SIX DAYS OR LESS.
For example, not going to work or school at all, or giving up housework altogether.

II: A SUBSTANTIAL DECREASE IN THE QUALITY OR QUANTITY OF ROLE PERFORMANCE THAT WOULD BE NOTICEABLE TO OTHERS.

You should ask:

1: What difficulties the subject had, and get examples.
2: If there were other people around who might have noticed.
3: Whether anyone remarked on the difficulties.

A rating of social impairment would usually require that someone had remarked that the subject was not functioning as well as usual. There are two exceptions. Firstly, in cases where there is no one present to remark on the difficulties (for example, if the subject is housebound), impairment may be rated if in the rater's judgement this would have been noticeable. Secondly, in cases where the subject has made substantial efforts to conceal impairment (for example, taking large amounts of work home).

TYPICAL EXAMPLES OF SOCIAL IMPAIRMENT: A man whose work has declined so that his boss comments. The housewife whose husband complains about the state of the house.

EXAMPLES THAT DO NOT QUALIFY: The person who feels their work has declined, but no one commented, and there is no evidence that a decline would have been observable.

SOCIAL INCAPACITATION: refers to cessation of function in the principal social role for 7 days or more. Hospitalization for 3 or more days is considered incapacitation, and ECT also rates as incapacitation. Note: ANY hospitalization that is the clear result of mental illness counts; for example, admission to hospital as a result of an overdose.

START OF SYMPTOM SCREENING AND PSYCHIATRIC SECTIONS

NOTE

I. SCREENING

The screens should be read out verbatim, unless the subject has already indicated the presence of a symptom, in which case use the subject's own words. For each screen that is affirmed, probe to establish the presence of the symptom, and to rate the severity. If the probes indicate a symptom is present, (2 or 3 coding) and the symptom has been relatively persistent for the required time, enter section.

II. EXAMPLES

For each question affirmed by the subject, get an example. This is particularly important in the treatment and impairment sections. ALWAYS WRITE DOWN EXAMPLES.

III. SYMPTOMS

In each section there is a list of symptoms associated with the disorder. The opening question is intended to get the subject to give his own account. After this use the probes to check on the presence or absence of other symptoms.

IV. SYMPTOM SEVERITY

For most symptoms the following convention applies:

0 = Symptom not present

1 = The 1 category includes :

- Symptoms that are doubtfully present at all. For example, the subject replies to a direct question by saying that he is not sure, or it was so long ago that he cannot quite remember. Definite "don't knows" are coded 9.

- Symptoms that are very mild and of doubtful clinical significance. For example, the subject took fifteen minutes longer to get off to sleep, once a week, but otherwise his sleep was unaffected.

2&3 = Symptoms coded 2 are definitely present, and of moderate intensity. Symptoms coded 3 are severe. In making the distinction between 2 and 3, you should take the factors below into account.

8 or 88 = not applicable

9 or 99 = not known

INTENSITY: eg: if a subject describes his depression as very bad, like a "black cloud", this would merit a rating of 3.

FREQUENCY: a very high frequency of some symptoms would be rated as 3. This applies to some "cognitive symptoms"; for example very frequent obsessional thoughts would be rated as 3.

PROPORTION OF TIME PRESENT: For example, more than 50% of the time would be one indication of severity.

AMOUNT: the severity of some symptoms is defined by amount. For example, weight loss.

Guidelines are given for most individual symptoms in the text. As a general rule, to be rated 3, symptoms should be severe, and last for most of the day. There is no 'dubious' category for psychotic symptoms.

GENERALIZED ANXIETY DISORDER : SCREENING QUESTIONS

Have you ever had times when you've felt anxious or frightened or worried for most of the day? (Tense jittery)

Have there ever been times when for most of the day you have had a feeling of dread, as though something terrible might happen?

What were you worried about?

How long did that last for?

NOTE: RDC REQUIRES TWO WEEKS : DSM IV REQUIRES SIX MONTHS!

Did you feel like that for most of the time? For more days than not?

IF SCREEN IS POSITIVE AND WAS RELATIVELY PERSISTENT FOR TWO WEEKS, COMPLETE SECTION.
IF NOT, GO TO PANIC DISORDER.

CHARACTERISTICS

How old were you when you first felt like that?

How many times have you felt like that?

(Has a past episode been followed by a remission of 2 months)

How long did the longest time last when you felt like that?

Have you felt like that recently? How long for?

When was the worst time? How old were you then?

TREATMENT/IMPAIRMENT (most severe episode, and/or current/onset)

During that time when you were age x did you seek help from anyone, like ....

A Doctor or other professional? A member of the Church? A friend?

Or did someone suggest you get help?

Did you take any medication?
(if yes, get details of drug, amount, duration, effects)

Did you have to stay in hospital

Was there a difference in how you managed at work/your household tasks etc.

Did it affect your social life? How about getting on with other people?

Did anyone comment on the difference? Do you think it was notieable to others?

How old were you when you first .... (any of above)

GENERALIZED ANXIETY DISORDER

SCREENING QUESTIONS

Generalised anxiety — 2 Weeks ____ 6 Months ____
1 doubtfully present
2 definitely present, moderate intensity or severe less than half the day
3 severe for more than half the day

CHARACTERISTICS

Age at onset of first symptoms ____ ____

Past episode followed by remission No= 0 Yes= 1 ____

Number of episodes (maximum of 50) ____ ____

Duration of longest: Weeks ____ ____ ____

Age at longest episode ____ ____

Currently in an episode No= 0 Yes= 1 ____

Duration of current episode: Weeks ____ ____ ____

TREATMENT/IMPAIRMENT (first, most severe, current)

Sought help from	First Child	First after 16	Most severe	Current
A professional (No = 0 Yes = 1)	____	____	____	____
Church (No = 0 Yes = 1)	____	____	____	____
Friend (No = 0 Yes = 1)	____	____	____	____
Other suggested seek help (No = 0 Yes = 1)	____	____	____	____
Medication(No = 0 Yes = 0)	____	____	____	____
Drugs/alcohol(No = 0 Yes = 1)	____	____	____	____
Hospitalized(No = 0 Yes = 1)	____	____	____	____
Social functioning (Not affected = 0; Impaired = 1; Incapacitated = 2)	____	____	____	____

Age of onset of impairment/incapacitation ____ ____

GENERALIZED ANXIETY DISORDER

SYMPTOMS

Were you able to put these worries out of your mind?
Could you control the worries if you tried?
Were they always going through your mind?

During the worst part, what sort of complaints bothered you?

OBTAIN AN ACCOUNT, THEN ASK THE FOLLOWING QUESTIONS WHERE THE ANSWERS HAVE NOT ALREADY BEEN VOLUNTEERED.

Were you bothered by ....

sweating a lot?

feeling restless?
(being unable to sit still)
(did you have to keep pacing up and down?)

feeling keyed up or on edge?

dizziness or faintness?

palpitations?

difficulty breathing?

being easily fatigued?
(feeling tired out even if you haven't been working hard?)

difficulty concentrating?
(or your mind going blank?
could you concentrate if you tried?)

worrying about things that might happen?

being irritable?

muscular tension? (did your muscles feel tensed up?)

problems sleeping?
(difficulties falling asleep
...or staying asleep
...or was your sleep restless or unsatisfying?)

GENERALIZED ANXIETY DISORDER : SYMPTOMS

For all symptoms:
1 = Mild, doubtfully present;
2 = Definitely present, moderate intensity, or severe intensity for less than half the day for most of the episode
3 = Severe form of symptom for more than half the day for most of the episode
Note: For insomnia, 2=>1 hr. lost, 3=>2 hrs. lost

Unable to put worries out of mind ____

Sweating a lot ____

Restlessness ____

Dizziness or faintness ____

Palpitations ____

Feeling keyed up ____

Difficulty breathing ____

Fatigue ____

Poor concentration ____

Worrying about things that might happen ____

Irritability ____

Muscular tension ____

Initial insomnia ____

Total sleep loss
(1 = slight, 2 => one hour lost, 3 = frequently > two hours) ____

Middle insomnia
(1 = occasional waking in night, 2 => one hour lost, 3 => two hours lost) ____

Early waking
(1 = occasional difficulty, 2 => one hour early, 3 => two hours early) ____

OTHER CHARACTERISTICS OF ANXIETY STATE

IF NOT ALREADY CLEAR, ASK:

During the times we've just talked about did you have any other symptoms or problems?
... like depression or panics?
Was it these problems that you were worried about?
? is the focus of the anxiety confined to features of another axis I disorder.
? did at least one episode occur at some time other than within two months of an episode of panic, depression, schizophrenic symptoms, or Briquet's.

IF YES:
Which do you think was worst? The anxiety or the depression/fears/panics?

Had you been physically ill around that time?
Had you taken any drugs or medication?

OTHER CHARACTERISTICS OF ANXIETY STATE

Association with other symptoms

0 = no, anxiety alone for all episodes
1 = yes, but at least one episode had anxiety alone
2 = yes, all episodes associated with other symptoms

Anxiety predominates

0 = no, for most or all episodes other symptomspredominated
1 = yes, but for a few episodes only
2 = yes, anxiety predominated for most or all episodes

Physical illness/drugs/medication

0 = no illness or substance use at that time
1 = possible illness or substance use but not related to anxiety
2 = anxiety related to substance use or general medical condition

SUMMARY FOR ANXIETY DISORDER

anxsect
anxiety disorder: section entered
0 No ____
1 Yes

anxRDC/anxDSM
anxiety disorder: diagnosis - currently or previously RDC____ DSM____
0 No
1 Previously
2 Currently
3 Both
8 Not applicable
9 Not known

anxagRDC/ansagDSM
anxiety disorder: age of onset RDC____ ____ DSM ____ ____

ansevRDC/ansevDSM
anxiety disorder age most severe RDC____ ____ DSM ____ ____

anepi RDC/anepiDSM
anxiety disorder: # of episodes RDC____ ____ DSM ____ ____
88 Not applicable
99 Not known

anxtrt
anxiety disorder: treatment
0 No ____
1 Yes
8 Not applicable
9 Not known

anxmed
anxiety disorder: medical condition
0 No ____
1 Yes
8 Not applicable
9 Not known

anxdur
anxiety disorder: duration (weeks:sum RDC and DSM) ____ ____ ____
888 Not applicable
999 Not known

anpatRDC/anpatDSM
anxiety disorder: pattern for disorder RDC____ DSM ____
0 None
1 Continuous
2 Hovers around threshold
3 On/off

PANIC ATTACKS/PANIC DISORDER

SCREENING QUESTIONS

Have you ever had attacks of fear or panic when you suddenly felt apprehensive or frightened?

Or even terrified?

Have you ever had times when you felt shaky, or your heart pounded, or you felt sweaty, and you had to do something about it?

PROBE BRIEFLY TO ESTABLISH THAT THESE ATTACKS ARE CIRCUMSCRIBED, DO NOT LAST FOR MORE THAN 2/3 OF THE DAY, AND ARE NOT ASSOCIATED WITH PHYSICAL EXERTION OR LIFE THREATENING SITUATIONS.
ENSURE THAT PANICS HAVE NO OBVIOUS ORGANIC BASIS.

IF HAD PANIC ATTACKS, COMPLETE PANIC DISORDER SECTION. IF NOT, GO TO PHOBIAS.

CHARACTERISTICS

How old were you when you first felt like that?

How many times have you felt like that?
(Has a past episode been followed by a remission of 2 months?)

How long did the longest time last when you felt like that?

Have you felt like that recently? How long for?

When was the worst time? How old were you then?

TREATMENT/IMPAIRMENT (first, most severe episode, and/or current)

During that time when you were age x did you seek help from anyone, like ....

A Doctor or other professional?

A member of the Church?

A friend?

Or did someone suggest you get help?

Did you take any medication? Or drink alcohol or take drugs to help?
(if yes, get details of drug, amount, duration, effects)

Did you have to stay in hospital?

Was there a difference in how you managed at work/your household tasks etc.
Did it affect your social life? How about getting on with other people?

Did anyone comment on the difference? Do you think it was noticeable to others?

How old were you when you first .... (any of above)

PANIC ATTACKS/PANIC DISORDER

SCREENING QUESTION

Panic attacks ____

1 = Doubtful
2 = Definite, 3 or less panics per week at most severe time
3 = Severe, 4 or more panics per week at most severe time

CHARACTERISTICS

Age at onset of first panic ____ ____

Past episode followed by remission (of 2 months) ____
No = 0 Yes = 1

Number of episodes ____ ____

Duration of longest: Weeks ____ ____ ____

Currently in episode ____
No = 0 Yes = 1

Duration of current episode: Weeks ____ ____ ____

TREATMENT/IMPAIRMENT (most severe episode, and/or current/onset)

Sought help from	First Child	First after 16	Most severe	Current
A professional (No = 0 Yes = 1)	____	____	____	____
Church (No = 0 Yes = 1)	____	____	____	____
Friend (No = 0 Yes = 1)	____	____	____	____
Other suggested seek help (No = 0 Yes = 1)	____	____	____	____
Medication(No = 0 Yes = 0)	____	____	____	____
Drugs/alcohol(No = 0 Yes = 1)	____	____	____	____
Hospitalized(No = 0 Yes = 1)	____	____	____	____
Social functioning (Not affected = 0; Impaired = 1; Incapacitated = 2)	____	____	____	____

Age of onset of impairment/incapacitation ____ ____

PANIC DISORDER: SYMPTOMS

During the worst of these attacks what sort of symptoms did you have?

OBTAIN AN ACCOUNT, THEN ASK THE FOLLOWING QUESTIONS WHERE THE ANSWERS HAVE NOT ALREADY BEEN VOLUNTEERED.

IF SYMPTOM PRESENT, WAS IT THERE FOR MOST OF THE ATTACK?

Were you bothered by ....

palpitations? (feeling your heart pounding)

sweating?

trembling?

shortness of breath? (or a smothering feeling?)

choking feelings?

chest pain or discomfort?

nausea or abdominal distress?

dizziness, feeling unsteady or lightheaded or faint?

a strange feeling that things were unreal?
(as though you were physically off from people, like a stage set)
or a feeling of being detached from yourself?

fear of losing control or going crazy?

fear of dying during the attack?

tingling feelings?

chills or hot flushes?

PANIC DISORDER: SYMPTOMS

For all symptoms

1 = Mild, doubtfully present
2 = Definitely present, during a panic attack
3 = Severe, and lasts for most of the panic attack

Palpitations	0	1	2	3	____
Sweating	0	1	2	3	____
Trembling	0	1	2	3	____
Shortness of breath	0	1	2	3	____
Choking	0	1	2	3	____
Chest pain	0	1	2	3	____
Nausea or abdominal distress	0	1	2	3	____
Dizziness	0	1	2	3	____
Derealization or depersonalization	0	1	2	3	____
Fear of losing control or going crazy	0	1	2	3	____
Fear of dying	0	1	2	3	____
Paraesthesia	0	1	2	3	____
Chills or hot flushes	0	1	2	3	____

OTHER CHARACTERISTICS OF ATTACKS

How long does/did it take from the start of the symptoms to the worst point?

(PROBE FOR AT LEAST 4 SYMPTOMS 10 MINUTES AFTER ONSET FOR DSM IV DIAGNOSIS)

How long does/did an attack last? (RECORD AVERAGE TIME WHEN MOST SEVERE .....)

How many attacks do/did you have in a typical week?

For how many weeks altogether did you have at least 1 attack each week?
(? had at least 6 panics over a 6 week period)

Did you expect that you would be very nervous or frightened in the places or the times you had the attacks?

Did anything happen that brought the attacks on? Were all attacks related to those situations? (GET DETAILS)

CHECK FOR NERVOUSNESS BETWEEN ATTACKS OVER A SIX WEEK PERIOD:

Were you nervous between attacks? How nervous?

CHECK FOR AT LEAST ONE MONTH DURATION FOLLOWING AN ATTACK:

During the next month did you....

worry about having another one?

worry about the implications of having an attack or its consequences?
for example worry about losing control, having a heart attack, going crazy?

was there a significant change in your behaviour?

Had you been physically ill around that time?
Had you taken any drugs or medication?

USE PHOBIA SECTION TO DECIDE WHETHER THIS IS PANIC DISORDER WITH OR WITHOUT AGORAPHOBIA

? HAD AT LEAST ONE EPISODE AT SOME TIME OTHER THAN WITHIN TWO MONTHS OF AN EPISODE OF DEPRESSION, SCHIZOPHRENIA, OR SCHIZO-AFFECTIVE DISORDER.

RDC
Requires 6 attacks distributed over 6 weeks, and nervousness between attacks.
Requires impairment, or seeking or referral for help, or (self?) medication.

DSM IV
Requires recurrent attacks, and at least one followed for one month (or more) by one (or more) of a)persistent concern about additional attacks, b) worry about implications, c) significant change of behaviour.

OTHER CHARACTERISTICS OF ATTACKS

Length of time from onset to four symptoms (mins) ____ ____ ____

Length of typical attack (mins) ____ ____ ____

Number of attacks in typical week
Attacks per week (max = 50) ____ ____

Had X panics over X weeks
0 No X = 4____ X = 6____
1 Yes

Expected to be very nervous
0 No ____
1 Yes

Nervous between attacks over 6 weeks
No = 0; Nervous not anxious = 1;
Anxiety = 2. ____

Relationship to external situations
0 = not at all ____
1 = some, but less than half related to certain situations
2 = most related to situations
3 = all related to situations, none occur spontaneously

One month persistent concern about additional attacks
0 No ____
1 Yes

One month worry about the implications of an attack
0 No ____
1 Yes

One month significant change in behaviour
0 No ____
1 Yes

Physical illness
0 = no illness or substance use at that time ____
1 = possible illness or substance use but not related to anxiety
2 = anxiety related to substance use or general medical condition

One episode without other disorder
0 No ____
1 Yes

SUMMARY FOR PANIC ATTACKS

Rate here panic attacks that are significant but that do not meet the criteria for Panic Disorder

panics
panic attacks - not DSMIV
0 No
1 Yes
8 Not applicable
9 Not known

SUMMARY FOR PANIC DISORDER

panic disorder: section entered (*pansect*) ____

0 No
1 Yes

panpre
panic disorder: diagnosis - currently or previously RDC____ DSM____

0 No
1 Previously
2 Currently
3 Both
8 Not applicable
9 Not known

panic disorder: age	*rdc1pan/dsm1pan*	First Child	RDC____ ____	DSM ____ ____
	rdc2pan/dsm2pan	First after 16	RDC____ ____	DSM ____ ____
	rdc3pan/dsm3pan	Most severe	RDC____ ____	DSM ____ ____
	rdc4pan/dsm4pan	Current	RDC____ ____	DSM ____ ____

panic disorder: # of episodes (*panepi*) RDC____ DSM____

88 Not applicable
99 Not known

panic disorder: treatment (*pantrt*) ____

0 No
1 Yes
8 Not applicable
9 Not known

panic disorder: medical condition (*panmed*) ____

0 No
1 Yes
8 Not applicable
9 Not known

pandur
panic disorder: duration (weeks: sum RDC and DSM) ____ ____ ____

888 Not applicable
999 Not known

panic disorder: pattern for disorder (*panpatt*) RDC____ DSM____

0 None
1 Continuous
2 Hovers around threshold
3 On/off

PHOBIAS/PHOBIC DISORDER

SCREENING QUESTIONS

Has there ever been a time when specific objects or situation have made you anxious or frightened?

For example, crowds, going out alone, animals, lifts, heights, blood, or being with people and making conversation.

IF YES: **Did you go out of your way to avoid these situations?** (How much? How often?)

What is it like when you can't avoid them?

PROBE FOR INTENSE ANXIETY AND DISTRESS IN THE SITUATION

IF NOT ALREADY CLEAR, CHECK:

How do you feel when you're exposed to [the object or situation]?

Did you ever have panics in those situations? How often?
DO NOT REPEAT QUESTIONS IF ALREADY ESTABLISHED IN PANIC DISORDER SECTION

IF PHOBIC AVOIDANCE EVER, OR ENDURED WITH INTENSE ANXIETY, OR FEAR OF PANIC, OR (AGORAPHOBIA) NEED FOR A COMPANION, COMPLETE THE REST OF THIS SECTION.

IF NOT, GO TO....

CHARACTERISTICS

How old were you when you first felt started to get anxious in those situations?

...or to avoid them?

How many times have you felt like that?

(Has a past episode been followed by a remission of 2 months)

How long did the longest time last when you felt like that?

Have you felt like that recently? How long for?

When was the worst time? How old were you then?

Do you feel its excessive or unreasonable to be afraid in this way?

NOTE: PHOBIA: IRRATIONAL FEAR OF AN OBJECT, SITUATION OR ACTIVITY WHICH THE SUBJECT AVOIDS. DO NOT INCLUDE AVOIDANCE OR FEARS DUE TO DELUSIONS, OR IRRATIONAL FEARS WITHOUT A TENDENCY TO AVOID SITUATIONS.

PHOBIAS/PHOBIC DISORDER

SCREENING QUESTIONS

Situational anxiety

None	= 0	____
Mild, doubtful significance	= 1	
Definitely present, moderate intensity of anxiety in such situations (or person feels would have been present had exposure occurred)	= 2	
Severe anxiety in such situations (or would have been present had exposure occurred)	= 3	

Maximum phobic avoidance/endurance

Note: avoidance should be shown by effects on behaviour or alterations of routine	None	= 0
	Mild, hardly ever avoided feared situation	= 1
	Moderate, definite avoidance/endurance present	= 2
	Severe, marked avoidance or endurance of feared situations.	= 3

Almost invariable immediate anxiety response

None = 0
Doubtful = 1
Moderate = 2
Severe = 3

Panic attacks

0 = none
1 = yes, but never related to feared situations
2 = yes, sometimes related to feared situations
3 = yes, often related to feared situations
4 = yes, always related to feared situations

CHARACTERISTICS

Age at onset of phobia ____ ____ ____

Past episode followed by remission
No = 0 Yes = 1 ____

Number of episodes (up to 50) ____ ____

Duration of longest
in weeks ____ ____ ____

Currently in episode
No = 0 Yes = 1 ____

Duration of episode
in weeks ____ ____ ____

Subjective unreasonable or excessive fear
No = 0 Yes = 1 ____

PHOBIC DISORDER TREATMENT/IMPAIRMENT
(most severe episode, and/or current/onset)

During that time when you were age x did you seek help from anyone, like ....

A Doctor or other professional?

A member of the Church?

A friend?

Or did someone suggest you get help?

Did you take any medication?
(if yes, get details of drug, amount, duration, effects)

Did you have to stay in hospital?

Was there a difference in how you managed at work/your household tasks etc.

Did it affect your social life? How about getting on with other people?

Did anyone comment on the difference? Do you think it was notieable to others?

How old were you when you first .... (any of above)

AVOIDANCE PROFILE

I would just like to check on some other fears that people sometimes have

DETERMINE WHICH TYPE OF PHOBIA IS MOST PROMINENT, CIRCLE THE SITUATIONS AVOIDED.

Agoraphobia: crowds, going out alone, being at home alone, enclosed or open spaces, travelling,standing in aqueue, being on a bridge.

Social phobia: fear of embarassment or humiliation or anxiety when meeting people, making conversation, speaking to an audience, eating/drinking/writing in front of other people, parties

Simple phobias: specific fears: animals, heights, storms, blood, injury, dentists, injections. Specify .....

AGORAPHOBIA
This typically involves a cluster of situations that lead to anxiety.

RDC
Requires impairment, medication or seeking or being referred for help.

DSM IV
Requires either impairment or marked distress about the phobia.

PHOBIC DISORDER TREATMENT/IMPAIRMENT

Sought help from	First Child	First after 16	Most severe	Current
A professional (No = 0 Yes = 1)	____	____	____	____
Church (No = 0 Yes = 1)	____	____	____	____
Friend (No = 0 Yes = 1)	____	____	____	____
Other suggested seek help (No = 0 Yes = 1)	____	____	____	____
Medication(No = 0 Yes = 0)	____	____	____	____
Drugs/alcohol(No = 0 Yes = 1)	____	____	____	____
Hospitalized(No = 0 Yes = 1)	____	____	____	____
Social functioning (Not affected = 0; Impaired = 1; Incapacitated = 2)	____	____	____	____
Age of onset of impairment/incapacitation		____	____	

AVOIDANCE PROFILE

Most prominent phobia ____

- Agoraphobia = 1
- Social phobia = 2
- Simple phobia = 3
- Other (specify) = 4
- Uncertain= 5

SUMMARY FOR PHOBIC DISORDER

phobic disorder: section entered (*phosect*)

0	No	____
1	Yes	

phopre
phobic disorder: DSM IV diagnosis - currently or previously

1	Previously	RDC____	DSM____
2	Currently		
3	Both		
8	Not applicable		
9	Not known		

phoage
phobic disorder:

age	*rdc1ph/dsm1ph*	First Child	RDC____ ____	DSM ____ ____
	rdc2ph/dsm2ph	First after 16	RDC____ ____	DSM ____ ____
	rdc3ph/dsm3ph	Most severe	RDC____ ____	DSM ____ ____
	rdc4ph/dsm4ph	Current	RDC____ ____	DSM ____ ____

phoepi
phobic disorder: # of episodes

88	Not applicable	RDC____	DSM____
99	Not known		

phobic disorder: treatment (*photrt*)

0	No	____
1	Yes	
8	Not applicable	
9	Not known	

phobic disorder: medical condition (*phomed*)

0	No	____
1	Yes	
8	Not applicable	
9	Not known	

phodur
phobic disorder: duration (weeks: sum RDC and DSM) ____ ____ ____

888	Not applicable
999	Not known

phopatt
phobic disorder: pattern for disorder RDC____ DSM____

0	None
1	Continuous
2	Hovers around threshold
3	On/off

OBSESSIONAL SYMPTOMS/OBSESSIVE COMPULSIVE DISORDER : SCREENING QUESTIONS

Have you ever found that you have to keep on checking things that you know you have already done?

Like doors, switches etc.

What happens when you try to stop? How often?

Do you find that you have certain routines that you have to keep to, like touching things or running through things in your mind, like counting or repeating words to yourself?

Why do you do that? [Is it aimed at reducing anxiety or preventing something happening? Is it a realistic way of achieving this or is it out of proportion?]

What happens when you try to stop? How often?

Have you ever spent a lot of time on personal cleanliness?

Like washing over and over again.

What happens when you try to stop? How often?

Do you ever find that thoughts, pictures or impulses that you don't want come into your head?

What about? [Not simply excessive worries about real life problems]

Are they your thoughts? Are they upsetting or frightening?

Do you try to get rid of them or ignore them?

What happens when you try to stop? How often?

Do you find it difficult to make decisions about even very trivial things?

Have you ever constantly agonized over the meaning of things? How often?

IF THE SUBJECT HAS HAD OBSESSIONS/COMPULSIONS, COMPLETE THIS SECTION.
IF NOT, GOT TO DEPRESSION.

CHARACTERISTICS

Do you think it is excessive or unreasonable to think/behave in this way?

How much time do you spend doing .... in a day?

An hour or more?

How old were you when you first felt like that?

How many times have you felt like that?

(Has a past episode been followed by a remission of 2 months)

How long did the longest time last when you felt like that?

Have you felt like that recently? How long for?

When was the worst time? How old were you then?

OBSESSIONS

Obsessions are stereotyped and repetitive thoughts, whose content is usually meaningless and which are often associated with conscious resistance. In contrast, brooding takes the form of thinking about potentially real circumstances. Compulsive actions should be distinguished from episodes of minor checking, the avoidance of anxiety provoking situations that occurs in phobias, or lapses of memory so that the subject is not really sure whether the door is closed etc. Note that activities that are potentially pleasurable (eg. compulsive eating) should not be rated here.

OBSESSIONAL SYMPTOMS/OBSESSIVE COMPULSIVE DISORDER

For all symptoms

1 = Doubtful, or have occurred on 2-3 occasions only
2 = Definitely present, moderate intensity or if severe, present < half the day, occurred on more than 2-3 occasions
3 = Severe intensity for more than half the day, occurred on more than 2-3 occasions

Checking	0	1	2	3	____
Cleaning and similar rituals	0	1	2	3	____
Obsessional thoughts	0	1	2	3	____
Obsessional doubts and rumination	0	1	2	3	____

CHARACTERISTICS

Thoughts/beaviours recognized as excessive
No = 0
Yes= 1 ____

Obsessions/Compulsions are time consuming (1 hour or more per day)
No = 0
Yes= 1 ____

Age at onset of first symptom
Age ____ ____ ____

Number of episodes (maximum of 50) ____ ____

Past episode followed by remission
No = 0
Yes= 1 ____

Duration of longest
Weeks ____ ____ ____

Currently in an episode
No= 0
Yes = 1 ____

Duration of current episode
Weeks ____ ____ ____

OBSESSIONS/OBSESSIVE COMPULSIVE DISORDER

TREATMENT/IMPAIRMENT
(first, most severe episode, or current/onset where appropriate)

When you were (age)....

Did you seek help from anyone, like....

A doctor or other professional?

A member of the Church?

A friend?

Or did someone suggest you get help?

Did you take any medication?
(If yes, get details of drug, amount, duration, effects)

Did you have to stay in hospital?

Was there a difference in how you managed at work/your household tasks etc.

Did it affect your social life? How about getting on with other people?

Did anyone comment on the difference? Do you think it was notieable to others?

How old were you when you first .... (any of above)

ADDITIONAL SYMPTOMS

Have you had any other symptoms apart from those we talked about?
Like depression or anxiety?

How did those affect you? Of the symptoms we have talked of, which affected you most? The depression/anxiety or the thoughts of rituals?

Have you avoided any particular situations because of the way you feel?

Had you been physically ill around that time?
Had you taken any drugs or medication?

OTHER CHARACTERISTICS
IF THERE ARE ADDITIONAL AXIS 1 DIAGNOSES, CHECK THAT THE CONTENT OF THE OBSESSIONS OR COMPULSIONS IS NOT RESTRICTED TO TO THEM.

OBSESSIONS/OBSESSIVE COMPULSIVE DISORDER : TREATMENT/IMPAIRMENT

Sought help from	First Child	First after 16	Most severe	Current
A professional (No = 0 Yes = 1)	____	____	____	____
Church (No = 0 Yes = 1)	____	____	____	____
Friend (No = 0 Yes = 1)	____	____	____	____
Other suggested seek help (No = 0 Yes = 1)	____	____	____	____
Medication(No = 0 Yes = 0)	____	____	____	____
Drugs/alcohol(No = 0 Yes = 1)	____	____	____	____
Hospitalized(No = 0 Yes = 1)	____	____	____	____
Social functioning (Not affected = 0; Impaired = 1; Incapacitated = 2)	____	____	____	____
Age of onset of impairment/incapacitation			____	____

ADDITIONAL SYMPTOMS

Are obsessions/compulsions the predominant symptoms? ____

No, other symptoms predominate	= 0
Symptoms about equal	= 1
Yes, obsessions or compulsions predominate over other symptoms (like anxiety or depression) for most episodes	= 2

Which predominates? ____

Neither obsessions or compulsions predominate	= 0
Obsessions predominate	= 1
Compulsions predominate	= 2

Avoidance associated with symptoms ____

No = 0
Yes = 1

Physical illness/drugs/medication ____

0 = no illness or substance use at that time
1 = possible illness or substance use but not related to anxiety
2 = anxiety related to substance use or general medical condition

OTHER CHARACTERISTICS

Obsessions/compulsions outside contexts of other disorders ____

No = 0
Yes = 1

SUMMARY FOR OBSESSIVE COMPULSIVE DISORDER

obsessive compulsive disorder: section entered (*ocdsect*) ____

0 No
1 Yes

ocdpre
ocd: diagnosis - currently or previously RDC____ DSM____

1 Previously
2 Currently
3 Both
8 Not applicable
9 Not known

ocd: age	*rdc1ocd/dsm1ocd*	First Child	RDC____ ____	DSM ____ ____
	rdc2ocd/dsm2ocd	First after 16	RDC____ ____	DSM ____ ____
	rdc3ocd/dsm3ocd	Most severe	RDC____ ____	DSM ____ ____
	rdc4ocd/dsm4ocd	Current	RDC____ ____	DSM ____ ____

ocdepi
phobic disorder: # of episodes RDC____ DSM____

88 Not applicable
99 Not known

phobic disorder: treatment (*ocdtrt*) ____

0 No
1 Yes
8 Not applicable
9 Not known

phobic disorder: medical condition (*ocdmed*) ____

0 No
1 Yes
8 Not applicable
9 Not known

ocddur
phobic disorder: duration (weeks: sum RDC and DSM) ____ ____ ____

888 Not applicable
999 Not known

ocdpatR/oocdpatD
phobic disorder: pattern for disorder RDC____ DSM____

0 None
1 Continuous
2 Hovers around threshold
3 On/off

DEPRESSIVE MOOD AND RELATED SYMPTOMS

SCREENING QUESTIONS

Did you ever have a time that lasted at least a week when you felt depressed for most of the time, or felt sad and down in the dumps?

How depressed did you feel? How bad was the feeling?

Or times when you've felt depressed for a few days. (How often? For how long?)

What about feeling irritable or easily annoyed?

Easily triggered off by what people said.
Did you shout or quarrel with people?
Did you hit anyone or break things?
How long did it last?

What about crying or tearfulness?

Or times when you just couldn't enjoy things?

Did you enjoy anything at that time?
Could you have changed things?

How long did the longest period last? Was your mood like that for most of the time?

Was there ever a time during that period when your mood lifted or you felt better?
Did that last for a month or so?
Was it for as long as two months?

ENTER SECTION....

IF SCORES TWO OR THREE ON ANY SYMPTOM AND THIS PERSISTED FOR ONE WEEK.

OR SCORES TWO OR THREE ON ANY SYMPTOM FOR LESS THAN ONE WEEK AND OCCURRED OFTEN FOR TWO YEARS

DEPRESSIVE MOOD AND RELATED SYMPTOMS

SCREENING QUESTIONS

Depressed mood
No = 0
Occasional feeling of sadness of doubtful significance = 1
Definite depressed mood of moderate intensity = 2
Severe, pervasive feelings of depression lasting for most of the day eg: "like a black cloud." = 3 ____

Irritability
No = 0
Doubtfu = 1
Moderate = 2
Severe = 3 ____

Crying
No = 0
Very occasional = 1
Daily = 2
Most of the time = 3 ____

Pervasive anhedonia
No = 0
Some activities less enjoyable = 1
A great number of activities not enjoyable = 2
All activities not enjoyable = 3 ____

Symptoms persisted continuously for?
None or less than 1 wk = 0
1 - 2 weeks = 1
More than 2, less than 4 weeks = 2
4 weeks or more = 3 ____

Symptoms occurred more days than not for two years with no two-month remission
No = 0
Yes = 1 ____

EPISODES OF DEPRESSION

CURRENT EPISODE (= current or within the past 2 months)

Have you felt like that recently If yes, get details.

When did it start?

Has anyone close to you died recently?

PAST EPISODES

And ~~what~~ about in the past

When was the first time that you felt like that?

Have there been times when you felt better?

How many times have you felt like that?
(50 if too numerous to count. Include grief reactions).

How long did the longest time last for?

How old were you when you last felt like that?

EPISODES OF DEPRESSION

Periods of dysphoric mood are categorized here if they are relatively discreet and are associated with other symptoms of Major and Minor Depression. These categories are distinguished from Generalized Anxiety Disorder, in which there is a clear predominance of anxious mood and from Labile Personality, in which the depressed mood rarely lasts for more than a few days at a time.

Code symptoms for episodes that are not grief reactions unless there are only grief reactions, in which case code these. Note: An episode is defined as a grief reaction if the onset is within three months following the death of someone close and there is substantial improvement within one year.

A period of Major and Minor Depression may be the only disturbance or may be superimposed upon another psychiatric disorder, including "Other Psychiatric Disorder".

EPISODES OF DEPRESSION

CURRENT EPISODE

In current episode
No = 0
Yes = 1 ___

Associated with death
No = 0
Yes = 1 ___

Date of onset of current symptoms
Month/year ___ ___/___ ___

Duration in weeks
Weeks ___ ___ ___

PAST EPISODES

Age of onset of first symptom
Age ___ ___.___

Past episode and remission
No = 0
Yes = 1 ___

Number of episodes
(Code up to 50 and 50 if too numerous to count) ___ ___

Duration of longest
Weeks ___ ___ ___

Age at last episode
(if more than one) ___ ___.___

DEPRESSION: MOST SEVERE EPISODE

FIND OUT WHICH EPISODE THE SUBJECT REGARDS AS THE MOST SEVERE (IF ONLY ONE EPISODE THIS IS THE MOST SEVERE)

Which one of the times that we have talked about was the worst?

When did that start?

How long did it last?

IF CURRENT: Is the way you feel now as bad as you did then?

Had anyone close to you died at that time?

YOU SHOULD NOW HAVE DETERMINED IF THERE IS A CURRENT EPISODE, AND IF THERE WERE PAST EPISODES, WHEN WAS THE FIRST BEFORE 16, THE FIRST A FTER 16 AND THE MOST SEVERE.
NOW GO THROUGH THE HELP SEEKING AND SYMPTOM SECTIONS FOR THE EPISODES .

TREATMENT/IMPAIRMENT

Did you seek help from anyone, like ....

A Doctor or other professional?

A member of the Church?

A friend?

Or did someone suggest you get help?

Did you take any medication?
(If yes, get details of drug, amount, duration, effects)

Did you have to stay in hospital?

IMPAIRMENT

Was there a difference in how you managed at work/your household tasks etc.
Did it affect your social life? How about getting on with other people?
Did anyone comment on the difference? Do you think it was noticeable to others?

How old were you when you first .... (any of above)

RDC

MAJOR DEPRESSION requires four weeks of depressed mood plus four associated symptoms with impairment or one week of functional role disruption. MINOR DEPRESSION requires two weeks of depressed mood and either impairment, or taking medication, or seeking help, or three associated symtoms

DSM

MAJOR DEPRESSION requires two weeks of five symptoms that must include either depressed mood or loss of interest, and either impairment or 'clinically significant distress'. MINOR DEPRESSION differs only in requiring between two and four symptoms.

DEPRESSION: MOST SEVERE EPISODE

Onset of symptoms
Month/year ____ ____/____ ____

Duration in weeks
Weeks ____ ____ ____

Current more severe
No = 0
Yes = 1 ____

Most severe associated with death
No = 0
Yes = 1 ____

TREATMENT/IMPAIRMENT

Sought help from	First Child	First after 16	Most severe	Current
A professional (No = 0 Yes = 1)	____	____	____	____
Church (No = 0 Yes = 1)	____	____	____	____
Friend (No = 0 Yes = 1)	____	____	____	____
Other suggested seek help (No = 0 Yes = 1)	____	____	____	____
Medication(No = 0 Yes = 0)	____	____	____	____
Drugs/alcohol(No = 0 Yes = 1)	____	____	____	____
Hospitalized(No = 0 Yes = 1)	____	____	____	____
Social functioning (Not affected = 0; Impaired = 1; Incapacitated = 2)	____	____	____	____
Age of onset of impairment/incapacitation			____	____

DEPRESSIVE SYMPTOMS

During these periods, what sort of symptoms or other complaints did you have?

OBTAIN AN ACCOUNT AND THEN ASK THE FOLLOWING QUESTIONS WHERE THE ANSWERS HAVE NOT ALREADY BEEN SUPPLIED.

Did the depressed feeling go away when you were involved with something that you usually enjoyed?
Or did you feel bad all the time?

What was your appetite like? (Were you eating less? Did you force yourself to eat?)
.... Did you have a poor appetite?
.... Or eat too much?

What about your weight?
.... Did you lose weight? (What is your height?)
.... Did you gain weight?
(how much?)

What was your sleep like at this time?
.... Did you sleep less?
.... Or more?
How much sleep did you lose?

.... What was the trouble with your sleeping?
did you have difficulty getting off to sleep?
or did you wake early?

Was the amount of energy you had any different?
Did you get tired more easily?
Your physical energy to do things?
How many activities did it affect?
Did you have to take a rest?

Were you still interested in your usual activities?
Like friends, TV., hobbies
Were there still things you enjoyed?

IF APPROPRIATE: **Did you lose you interest in sex?**
Were you going out with anyone at that time?
Were you interested in going out with anyone?

DEPRESSIVE SYMPTOMS

	First Child	First after 16	Most severe	Current
Mood improved with positive events 1 = uncertain ; 2 = yes	____	____	____	____
Loss of appetite 1 = mild 2 = clinically significant 3 = severe	____	____	____	____
Increased appetite As for loss of appetite.	____	____	____	____
Loss of weight 1 = 2 - 6 pounds lost 2 = more than 6 pounds 3 = more than one stone	____	____	____	____

Height ? _____ Weight at start of period? _____ Amount of weight lost?_____ %body weight lost?_____

Weight gain As for weight loss	____	____	____	____
Hypersomnia 1 = occasionally sleeps more than usual 2 = frequently oversleeps by one hour. 3 = frequently oversleeps > 2 hours.	____	____	____	____
Insomnia 1 = slight loss of sleep. 2 => one hour lost. 3 = frequently > 2 hours lost.	____	____	____	____
Delayed sleep 1 = occasional difficulty getting off 2 => one hour delay 3 => two hour delay.	____	____	____	____
Middle insomnia 1 = occasional walking in the night 2 => one hour lost. 3 = > two hours lost.	____	____	____	____
Early waking 1 = occasional difficulty. 2 => one hour early 3 => two hours early.	____	____	____	____
Loss of interest 1 = a few activities less interesting 2 = many activities less interesting 3 = severe, most activities less interesting	____	____	____	____
Loss of interest in sex 1 = mild ; 2 = moderate ; 3 = severe.	____	____	____	____
Loss of energy 1 = mild 2 = definite 3 = severe, involving most activities	____	____	____	____

DEPRESSIVE SYMPTOMS : CONTINUED

Did you have trouble concentrating, thinking, making decisions?
What difficulties did it cause?
Was that because you couldn't concentrate, or just because weren't interested?

Did you think about death or suicide?
Did you plan a way to do it?

Did you try to take your own life?

Were you able to sit still, or did you have any difficulty?
How long could you sit down for?
Did you wring your hands?

Did you notice that your movements were slowed down at all?
can you give me an example?
(Do not rate on subjective feeling alone)
Did you sit in one position for hours?

Were your thoughts or speech slowed?

Did you have any physical complaints that did not seem to be caused by any sort of physical illness? For example, something like headaches? Did you worry much about these?
.... or constipation?

.... or something else (record the details)

DEPRESSIVE SYMPTOMS : RATING

	First Child	First after 16	Most severe	Current
Difficulty concentrating 1 = mild 2 = definitely present, moderate 3 = severe, most activities affected	____	____	____	____
Suicidal ideation 1 = occasional thoughts of death, no plans 2 = seriously considered, or plans 3 = planned and prepared a method	____	____	____	____
Suicidal attempt 1 = yes	____	____	____	____
Agitation 1 = Slight 2 = Significant, but moderate 3 = Mostly pacing/on the move	____	____	____	____
Retarded movements 1 = slight 2 = moderate 3 = severe, eg. sits for hours	____	____	____	____
Retarded thoughts/speech 1 = slight 2 = significant but moderate 3 = severe, almost mute/mute	____	____	____	____
Hypochondriasis 1 = doubtful 2 = definite over concern about health 3 = constant preoccupation	____	____	____	____
Constipation 1 = uncertain 2 = yes	____	____	____	____
Other physical 1 = mild 2 = moderate 3 = severe	____	____	____	____

Symptom Coding	Age of Onset	Mentioned To Physician (No=0 yes=1)	Took Medication (No=0 yes=1)	Alteration of Life pattern (None=0 yes=1)
____	____ ____	____	____	____

DEPRESSIVE SYMPTOMS CONTINUED

Did/do you feel guilty about things, or blame yourself a great deal?
(What about? How much? All the time?)

(? delusions of guilt)

How did/do you feel about the future?
Did you feel hopeless about things?

Did/do you brood about the unpleasant things that happened?
Can you give me an example?

Did/do you feel inadequate or disappointed in yourself?

Did/do you feel irritable or angry?
Did you shout or quarrel with people?

At what time of the day were/are your symptoms worse?

DEPRESSIVE SYMPTOMS CONTINUED

	First Child	First after 16	Most severe	Current
Self-reproach 1 = mild feelings of self-blame 2 = often felt guilty about the past 3 = severe, constant feelings of guilt about most areas of functioning	____	____	____	____
Delusions of guilt 1 = Suspected or likely 2 = Definite	____	____	____	____
Hopelessness 1 = occasional feelings of mild discouragement about the future 2 = definite hopelessness, but still has some hope 3 = given up all hope.	____	____	____	____
Brooding 1 = occasional worries about some realistic problem 2 = often 3 = extreme brooding and preoccupation about problems	____	____	____	____
Inadequacy 1 = mild feelings of inadequacy 2 = often feels like a failure 3 = frequent, severe feelings of being a failure	____	____	____	____
Irritability 1 = occasionally gets more irritable 2 = often aware of feeling angry 3 = very angry	____	____	____	____
Diurnal variation Same = 0 AM worse = 1 PM worse = 2	____	Same = 0 AM worse = 1 PM worse = 2		____

DEPRESSIVE SYMPTOMS: CONTINUED

DEPRESSIVE SYNDROMES: ONSET AND POSSIBLE PRECIPITANTS FOR ALL EPISODES

Was there anything happening in your life at that time?

GET DETAILS

Were you taking any medication or any other drugs before you became depressed?
Like blood pressure tablets, cortisone, the pill?

GET DETAILS

Had you been physically ill before you became depressed?

GET DETAILS

How many days did it take for you to go from your usual self to the worst part of your depression?

Were you unusually cheerful or energetic at any time just before, during or after your depression?

OTHER CHARACTERISTICS

? ALL EPISODES associated with ....
.... puberty

.... pregnancy or childbirth (within two months)

.... the Menopause (within three years)

? EVER received E.C.T. for depression

? Did ALL EPISODES occur within three months of the death of someone close

For chronic (> 2 years) symptoms, is this -
0 Sub threshold
1 Dysthymia
2 Chronic depression

DEPRESSIVE SYNDROMES: ONSET AND POSSIBLE PRECIPITANTS FOR ALL EPISODES

All episodes associated with medication or other drugs that may provoke depression (see manual)
No = 0
Uncertain = 1 ____
Yes = 2

All episodes associated with physical illness that may provoke depression or leads to a major change in life circumstances (see manual)
No = 0 ____
Uncertain = 1
Yes = 2

Duration from onset to full blown conditions for all episodes
Always within 48 hours = 1 ____
Most within 48 hours = 2
Some took more than 48 hours = 3
All took more than 48 hours = 4

Mood elevation associated with depression
No = 0 ____
Uncertain = 1
Yes = 2

OTHER CHARACTERISTICS

All episodes associated with:
No = 0 Yes = 1

Puberty ____

Pregnancy or childbirth ____

The menopause ____

Ever received E.C.T. for depression
No = 0 Yes = 1 ____

All episodes occurred within 3 months of the death of someone close
No = 0 Yes = 1 ____

For chronic (> 2 years) symptoms, is this -
0 Sub threshold ____
1 Dysthymia
2 Chronic depression

SUICIDAL BEHAVIOUR

SCREENING QUESTION

Have you ever tried to harm yourself or take your own life?

Have you ever taken an overdose or anything like that?

If YES: GET SUFFICIENT DETAILS TO OBTAIN THE ANSWERS TO THE FOLLOWING 5 QUESTIONS

If NO: GO TO MANIA.

CHARACTERISTICS

How many times?

When was the first?

Number **of gestures and/or attempts**

What were you doing at the time?

Where were you?

What did you do?

Was there anyone else around?

How were you found?

(Suicidal intent: Record the intent at the time of the MOST SERIOUS attempt in the box opposite. The rating of intent should be made by considering factors such as likelihood of being rescued, precautions against discovery, getting help during or after the attempt, degree of planning, the method (and particularly the subject's assessment of risk), and the presence of a final act (e.g. a note). This is primarily an observer rating to be based on the subject's behaviour and not on his/her statements about intent.)

What happened afterwards?

Did you go to hospital?

For how long?

What did they do?

How ill were you?

(Actual threat to life: At the time, or after, the episode. Consider the method (slashed throat more serious than a few Valium), impaired consciousness, amount of treatment required. Record the MOST SERIOUS in the column opposite.)

Occurred during an episode of specified illness

Rate yes if ANY of the attempts occurred during ANY of the specified episodes

REPEATED EPISODES OF DELIBERATE SELF HARM

Have you ever tried to harm yourself in any other ways?

For instance by cutting yourself. Have you ever tried to disfigure yourself?

SUICIDAL BEHAVIOUR

SCREENING QUESTION

Suicidal gesture/attempt ____
No = 0
Yes = 1

CHARACTERISTICS

Number (code up to 50) ____ ____

Age at first suicidal attempt ____ ____ . ____

Observer's rating of suicidal intent at most serious attempt ____

No intent, or minimal intent (e.g.: took a few tablets thinking this would not be harmful, little planning, made sure that somebody else knew or phoned medical services) = 0
Moderate intent (e.g.: a mixture of 0 and 2) = 1 Serious intent (e.g: used a method that was perceived as dangerous, planned, took precautions to avoid
discovery, settled affairs, left a note) = 2

Actual threat to life at most serious attempt ____
No dang
Minimal, eg: scratch on wrists = 1
Mild, eg: a few tablets with mild side effects = 2
Moderate, eg: definite effects, unconscious = 3
Severe, eg: cut throat = 4
Extreme, eg: prolonged coma = 5

Occurred during...	No	Yes	
Depression	0	1	____
Alcoholism	0	1	____
Drug abuse	0	1	____
Psychosis	0	1	____

Repeated deliberate self harm with 0 or minimal intent ____
No = 0
1-2 = 1
3 or more episodes of deliberate self harm with zero, or minimal intent to endanger life = 2

Type of self harm
(Code as above)

Overdose ____

Cutting ____

Other self injury ____

SUMMARY FOR DEPRESSION SECTION

Depression

depsect

depression: section entered

0	No	____
1	Yes	

PmajdepD/PmajdepR

Major depression - Previous

0	No	RDC____	DSM____
1	Probable		
2	Definite		

CmajdepR/CmajdepD

Major depression - Current

0	No	RDC____	DSM____
1	Probable		
2	Definite		

MindepR/MindepD

minor depression: diagnosis - currently or previously

0	No	RDC____	DSM____
1	Previously		
2	Currently		
3	Both		
8	Not applicable		
9	Not known		

major depression: age	*Rmaj1dep/Dmaj1dep*	First Child	RDC____ ____	DSM ____ ____
	Rmaj2dep/Dmaj2dep	First after 16	RDC____ ____	DSM ____ ____
	Rmaj3dep/Dmaj3dep	Most severe	RDC____ ____	DSM ____ ____
	Rmaj4dep/Dmaj4dep	Current	RDC____ ____	DSM ____ ____
minor depression: age	*Rmin1dep/Dmin1dep*	First Child	RDC____ ____	DSM ____ ____
	Rmin2dep/Dmin2dep	First after 16	RDC____ ____	DSM ____ ____
	Rmin3dep/Dmin3dep	Most severe	RDC____ ____	DSM ____ ____
	Rmin4dep/Dmin4dep	Current	RDC____ ____	DSM ____ ____

NomajdepINomindep Major ____ ____ Minor ____ ____

depression: # of episodes

88	Not applicable
99	Not known

deptrt

depression: treatment

0	No	____
1	Yes	
8	Not applicable	
9	Not known	

depmed
depression: medical condition
0 No ____
1 Yes
8 Not applicable
9 Not known

Dumajdep/Dumindep
depression: duration (weeks : sum RDC and DSM) Major____ ____ ____ Minor____ ____ ____
888 Not applicable
999 Not known

deppatR/deppatD
major depression: pattern for disorder
0 None RDC____ DSM____
1 Continuous
2 Hovers around threshold
3 On/off

DYSTHYMIA

dyspre
dysthymia: DSM IV diagnosis - currently or previously
0 No ____
1 Previously
2 Currently
3 Both
8 Not applicable
9 Not known

dysage
dysthymia: age of onset ____ ____ ____ ____

dysepi ____ ____
panic disorder: # of episodes
88 Not applicable
99 Not known

dystrt
dysthymia: treatment
0 No ____
1 Yes
8 Not applicable
9 Not known

dysdur
dysthymia: duration (weeks) ____ ____ ____
888 Not applicable
999 Not known

ddyspatt
dysthymia: pattern for disorder ____
0 None
1 Continuous
2 Hovers around threshold
3 On/off

ELEVATED MOOD/MANIC SYNDROMES

SCREENING QUESTIONS

Did you ever have a period that lasted at least four days when you felt unusually high and on top of the world, that was clearly different from your normal self?

If yes: Can you think of any reason?
Was there anything happening in your life at that time?
Do you think you might have been too cheerful to be healthy?
How long did it last?

If not clear, check:

Did it last as along as a week?

Did anyone say that this was more than just feeling good?

What about the periods when you felt very excitable or angry?

Easily triggered off by what people said, or very irritable.
Can you think of a reason why you were like that?
Did you hit anyone or break things?
How long did it last?

NB CAPS; Depression screening question

If YES, **Those feelings that you told me about, how much of the day did they last for?**

Were they present for most of the time?

IF THE SUBJECT HAS HAD AN EPISODE OF ELEVATED OR EXCITABLE MOOD, THIS LASTED FOR FOUR DAYS OR MORE, AND THE SYMPTOMS WERE PRESENT FOR MOST OF THE TIME, COMPLETE THIS SECTION.

IF NOT, GO TO DEREALIZATION.

RDC
MANIA Requires elevated mood plus three manic symptoms for more than a week or terminated by ECT, plus disrupted, conversation or fucntioning, or psychotic features. HYPOMANIA Requires elevated mood for two days (or irritated mood for seven days) plus two manic symptoms or impairment or marked improvement or sought help.

DSM
MANIA Requires elevated mood plus three manic symptoms for at least one week (or any duration if hospitalized) plus impaired functioning or psychotic features or hopitalization. HYPOMANIA Requires elevated or irritated mood for four days plus three manic symptoms plus change of functioning, plus change of mood or fucntioning that is observable to others but not severe enough to cause marked impairment, and no psychotic features.

ELEVATED MOOD/MANIC SYNDROMES

SCREENING QUESTIONS

Elevated mood for four days or more

Do not include transient high spirits, or feeling good in contrast to episodes of depression. To rate 2 the mood will usually be out of proportion to circumstances

No = 0 ——
More cheerful than most people in the circumstances, but of doubtful clinical significance = 1
Mood was/is definitely elevated = 2
Mood was/is elated, felt extremely good = 3

Elevated mood for seven days or more

Rate as above ——

Others commented on mood being abnormal

No = 0 ——
Yes = 1

Excitability/irritability for 2 days or more

No = 0 ——
More excitable or irritable than usual, but of doubtful significance = 1
Definitely more excitable or irritable eg. often shouts or loses his temper in circumstances which would not usually provoke this = 2
Shows anger by physical means eg. breaking things, physical assault = 3

NB Depression ——
1 = doubtful
2 = moderate
3 = severe

ELEVATED MOOD/MANIC SYNDROMES: CHARACTERISTICS

How old were you when you first felt like that
(get details)

How many times have you felt like that?
Has a past episode been followed by a remission of 2 months?

How long did the longest time last for when you felt like that?

Have you felt like that recently? How long for?

How long did the longest time last for?

When was the worst time?

CYCLOTHYMIA

Was there ever a time when you felt like that on a number of occasions? How many times a year? For how many years?

And were you at all depressed during those times?

PROBE TO ESTABLISH WHETHER THERE WERE DYSTHYMIC SYMPTOMS DURING THIS 2 YEAR PERIOD
(refer back to depression section)

ELEVATED MOOD/MANIC SYNDROMES: CHARACTERISTICS

PAST EPISODES

Age at onset of first symptom

___ ___.___

Episode followed by remission
No = 0
Yes = 1 ___

Number of episodes[8] (code up to 50, and 50 if too numerous to count)

___ ___

Age at last episode

___ ___.___

Duration of longest
Weeks/Days ___ ___ ___/ ___

CURRENT EPISODE

Currently in an episode
No = 0
Yes = 1 ___ ___

Duration
Weeks/Days ___ ___ ___/ ___

MOST SEVERE EPISODE

Onset
Month/year ___ ___/___ ___

Numerous periods of elevated/irritable mood during at least a two year period
No = 0
Uncertain = 1
Yes = 2 ___

Numerous periods of dysthymic mood during the same two year period
No = 0
Uncertain = 1
Yes = 2 ___

CYCLOTHYMIA

Age onset

___ ___.___

ELEVATED MOOD/MANIC SYNDROMES

Establish which episode the subject regards as the most severe. For this episode, determine treatment, impairment and symptoms (probe briefly into current/onset episodes where appropriate).

TREATMENT/IMPAIRMENT

During that time when you were age x ....

Did you seek help from anyone, like ....

.... **A Doctor or other professional?**

.... **A member of the Church**

.... **A friend**

Or did someone suggest you get help?

Did you take any medication?
If yes, get details of drug, amount, duration, effects.

Did you have to stay in hospital?

Did/does it get in the way of your life?
How about things at work/school?
Has it effected your social life? Stopped you doing things?
How about getting on with other people?

Does it bother you?

How old were you first .... (any of above)

ELEVATED MOOD/MANIC SYNDROMES

TREATMENT/IMPAIRMENT

Sought help from:	No	Yes	
A professional	0	1	____
Church	0	1	____
Friend	0	1	____

Other suggested seek help 0 1 ____

Medication 0 1 ____

Hospitalized 0 1 ____

Social functioning ____
Not affected = 0
Impaired = 1
Incapacitated = 2
Marked improvement, much better than usual performance for any person in the same role = 3

Age at onset of imp/inc ____ ____ . ____

ELEVATED MOOD/MANIC SYNDROMES: SYMPTOMS

During the most severe period, what sort of symptoms did you have?
(obtain an account, then ask the following questions where the answers have not been volunteered)

Were you more active than usual?
(get examples)
How much of the day would you spend like this?)

.... socially?

.... at work?

.... sexually?

.... physically?

Did you speak very rapidly, or talked on and on and could not be stopped?

Do you think you were so excited that it was almost impossible to have a conversation with you?

Were your thoughts racing?
Did you have more ideas than usual?

Do you think you were more efficient at work, or had any special powers or talents quite out of the ordinary?
Did you think you were a particularly important person?

What was your sleep like?
How much sleep did you lose?

ELEVATED MOOD/MANIC SYNDROMES: SYMPTOMS

Motor overactivity

Note: Ensure that overactivity actually occurred and was not merely a subjective feeling. Get examples of behaviour.

1 = Mild, doubtfully present
2 = Definitely present, moderate
3 = Severe, pervasive (occurs in most situations or on most occasions)

Social	0	1	2	3	____
Work	0	1	2	3	____
Sexual	0	1	2	3	____
Physical	0	1	2	3	____

Accelerated speech ____

No = 0
Doubtful = 1
Moderate, eg: conversation strained = 2
Severe, eg: conversation very difficult to maintain = 3

Symptoms so severe that conversation almost impossible ____

No = 0
Yes = 1

Accelerated thinking ____

No = 0
Suspected, likely = 1
Definite experiences that thinking was markedly accelerated = 2

Grandiosity ____

No = 0
Is more confident than usual but of doubtful significance = 1
Definitely inflated self esteem clearly out of proportion to circumstances = 2
Severe, eg: clear grandiose delusion = 3

Sleep ____

Less than 1 hour lost = 1
One hour or more lost = 2
Two hours or more lost = 3

ELEVATED MOOD/MANIC SYNDROMES: SYMPTOMS

If you were doing something like working or cooking, could you stick at it. How long for?
Or did your attention keep jumping to things around you?

Did you spend or borrow more money than you usually do?
How much?

Did you dress differently from usual?
Did you dress in a rather loud way?

Did you think that you were hard to get along with, or caused difficulty to people around you?
(get examples)

So would you say there was a definite difference in the way you were/are behaving (during that time)?
Do you think this was uncharacteristic of your usual self?

Did anyone else comment on it?

Looking back at that time do you think that you did anything because of your illness that showed poor judgement?
(get examples)

ELEVATED MOOD/MANIC SYNDROMES: SYMPTOMS

Distractibility

No = 0 ____
Some difficulty keeping to a task of doubtful significance = 1
Definitely more distractible, moderate = 2
Severe distractibility, can hardly stick at something for more than a few minutes before rushing on to something else = 3

Spent/borrowed excessive amounts of money

(rate on the subject's account)
No = 0 ____
Uncertain = 1
Yes = 2

Dressed in unusual/loud manner

No = 0 ____
Uncertain = 1
Yes = 2

Caused difficulty to other people

No = 0 ____
Slight, eg: called on friends at odd hours = 1
Moderate, eg: frequently woke up the family by doing the hoovering at 3.00 am. = 2
Severe, eg: spent family savings on worthless business speculation = 3

Different/uncharacteristic behaviour

None = 0 ____
Slight = 1
Moderate = 2
Severe = 3

Observer's rating of poor judgement

[Excessive involvement in activities without recognizing the high potential for painful consequences to self or others. This rating should be made by the observer on the basis of the whole interview, and not just on the subject's reply to the probe.]

None = 0 ____
Slight, eg: could cause minor difficulties to self or others = 1
Moderate = 2
Severe = 3

MANIC SYNDROMES: OTHER CHARACTERISTICS

We've talked about the most severe episode you had. I'd now like you to think about all the episodes when you've felt like .... (symptoms)

Did you have electrical shock treatment during any of the episodes when you were feeling high or excitable?

If yes, did it help with your symptoms?

Were you depressed or feeling down for a few days just before, during, or after the time when you felt high or excitable?

Were you taking any medications, drugs, or having any kind of treatment just before these episodes? (get details)

Were you taking any other drugs?

Were you drinking?

Did you have any sort of physical illness?
(get details)

? ALL EPISODES associated with :

Puberty

Pregnancy or childbirth (within 3 months)

Menopause (within 3 years)

MANIC SYNDROMES: OTHER CHARACTERISTICS

Ever had E.C.T. during any episode
No = 0
Yes = 1 ____

E.C.T. terminated manic features
No = 0
Yes = 1 ____

Depression closely associated with any episode
No = 0
Yes = 1 ____

All episodes preceded by somatic treatment that might provoke manic syndrome (see manual)
No = 0
Uncertain = 1
Yes = 2 ____

All episodes preceded by physical illness that might provoke mania, or lead to major life change
No = 0
Uncertain = 1
Yes = 2 ____

All episodes associated with alcohol intoxication
No = 0
Uncertain = 1
Yes = 2 ____

All episodes associated with puberty
No = 0
Yes = 1 ____

All episodes associated with pregnancy or childbirth
No = 0
Yes = 1 ____

All episodes associated with menopause
No = 0
Yes = 1 ____

SUMMARY FOR MANIC SECTION

mansect
mania: section entered
0 No
1 Yes ____

Hypomania

hyppre
hypomanic: DSM IV diagnosis - currently or previously
0 No ____
1 Previously
2 Currently
3 Both
8 Not applicable
9 Not known

hypage
hypomanic: age of onset ____ ____ . ____ ____
(calculate months as a fraction ie 9 months = 0.75)

hyptime
hypomanic: time after accident for onset in months ____ ____
88 Not applicable
99 Not known

hypepi ____ ____
hypomanic: # of episodes
88 Not applicable
99 Not known

hyptrt
hypomanic: treatment
0 No ____
1 Yes
8 Not applicable
9 Not known

hypmed
hypomanic: medical condition
0 No ____
1 Yes
8 Not applicable
9 Not known

hypdur
hypomanic: duration (weeks) ____ ____ ____
888 Not applicable
999 Not known

hyppatt
hypomanic: pattern for disorder ____
0 None
1 Continuous
2 Hovers around threshold
3 On/off

Bipolar I

bilpre
bipolar I: DSM IV diagnosis - currently or previously

0	No	____
1	Previously	
2	Currently	
3	Both	
8	Not applicable	
9	Not known	

bilage
bipolar 1: age of onset ____ ____ ____ ____
(calculate months as a fraction ie 9 months = 0.75)

biltime
bipolar 1: time after accident for onset in months ____ ____

88	Not applicable
99	Not known

bilepi ____ ____
bipolar 1: # of episodes

88	Not applicable
99	Not known

biltrt
bipolar 1: treatment

0	No	____
1	Yes	
8	Not applicable	
9	Not known	

bilmed
bipolar 1: medical condition

0	No	____
1	Yes	
8	Not applicable	
9	Not known	

bildur
bipolar 1: duration (weeks) ____ ____ ____

888	Not applicable
999	Not known

bilpatt
bipolar 1: pattern for disorder ____

0	None
1	Continuous
2	Hovers around threshold
3	On/off

Bipolar II

bi2pre
bipolar II: DSM IV diagnosis - currently or previously
- 0 No
- 1 Previously
- 2 Currently
- 3 Both
- 8 Not applicable
- 9 Not known

bi2age
bipolar II: age of onset ____ ____ . ____ ____
(calculate months as a fraction ie 9 months = 0.75)

bi2time
bipolar II: time after accident for onset in months ____ ____
- 88 Not applicable
- 99 Not known

bi2epi ____ ____
bipolar II: # of episodes
- 88 Not applicable
- 99 Not known

bi2trt
bipolar II: treatment
- 0 No
- 1 Yes
- 8 Not applicable
- 9 Not known

bi2med
bipolar II: medical condition
- 0 No
- 1 Yes
- 8 Not applicable
- 9 Not known

bi2dur
bipolar II: duration (weeks) ____ ____ ____
- 888 Not applicable
- 999 Not known

bi2patt
bipolar II: pattern for disorder ____
- 0 None
- 1 Continuous
- 2 Hovers around threshold
- 3 On/off

Cyclothymia

cycpre
cyclothymia: DSM IV diagnosis - currently or previously

0	No	____
1	Previously	
2	Currently	
3	Both	
8	Not applicable	
9	Not known	

cycage
cyclothymia: age of onset ____ ____ . ____ ____
(calculate months as a fraction ie 9 months = 0.75)

cyctime
cyclothymia: time after accident for onset in months ____ ____

88	Not applicable
99	Not known

cycepi ____ ____
cyclothymia: # of episodes

88	Not applicable
99	Not known

cyctrt
cyclothymia: treatment

0	No	____
1	Yes	
8	Not applicable	
9	Not known	

cycmed
cyclothymia: medical condition

0	No	____
1	Yes	
8	Not applicable	
9	Not known	

cycdur
cyclothymia: duration (weeks) ____ ____ ____

888	Not applicable
999	Not known

cycpatt
cyclothymia: pattern for disorder ____

0	None
1	Continuous
2	Hovers around threshold
3	On/off

DEREALIZATION AND DEPERSONALIZATION

Have you ever had the feeling that things around you were unreal?
As though you were physically cut off from people, like a stage set?
As though people appear colourless, and seem to act rather than be themselves?

NB Panics - check outside of panic attacks

Have you yourself felt unreal, that you were not a person?
As though you were outside yourself?
That you were not in the real world?

IF YES, get details of onset, duration, severity, and the circumstances surrounding the symptoms. Inquire about associated symptoms. If these suggest a psychiatric disorder, proceed to the relevant section.

IF NOT, GO TO PSYCHOSIS.

DEREALIZATION AND DEPERSONALIZATION

Derealization

No = 0 ——
Mild form, of doubtful significance = 1
Definitely present, moderately intense = 2
Severe, persistent, eg: people appear like puppets = 3

NB Panics - check outside attacks

Depersonalization

No = 0 ——
Mild form, of doubtful significance = 1
Definitely present, moderately intense = 2
Severe, persistent, eg: subject feels he is not a person = 3

DELUSIONS, HALLUCINATIONS, EPISODES OF PSYCHOSIS

SCREENING QUESTIONS

NOTE: ALWAYS WRITE DOWN VERBATIM EXAMPLES

Has your imagination ever played tricks on you?

Have you ever had the feeling that something odd is going on which you can't explain?

Have you ever had ideas that other people might not understand?

Has there been anything unusual about the way things looked, sounded, or smelled?

Have you ever heard voices when nobody was about?

Have you ever had a vision that other people couldn't see?

Have you ever felt that people were talking about you, or were out to get you?

IF EVIDENCE OF PSYCHOSIS, PROBE, AND COMPLETE PSYCHOSIS SECTION WHEN INDICATED

(Note: Many people who are not psychotic will give a positive reply to some of these questions. Therefore, unlike other sections, a positive reply does not necessarily mean the section should be entered).

IF NO EVIDENCE, GO TO DRUG SECTION.

PROBING GUIDE

When was the that?
What was it like?
How long did it last?
How often did it happen?
What did you do about it?
Did other people say anything?

Tricks
No = 0
Yes = 1 ____

Delusional mood
No = 0
Yes = 1 ____

Overvalued ideas/ delusional thoughts
No = 0
Yes = 1 ____

Hallucinations (non-auditory)
No = 0
Yes = 1 ____

Auditory hallucinations
No = 0
Yes = 1 ____

Visual hallucinations
No = 0
Yes = 1 ____

Paranoid ideation
No = 0
Yes = 1 ____

Any evidence of psychosis?
No = 0
Yes = 1 ____

PSYCHOSIS: ASSOCIATION WITH OTHER FACTORS

Were you drinking a lot then, or had you just stopped?

Were you taking any drugs, like speed or LSD?

Were you physically ill then?
(get details)

ONSET: this information may already have been elicited, if not determine whether -

How long did those feelings take to come on?

Did anything happen before?
(Record example and discuss with team)

(Were you pregnant?)

Drink
No = 0
Uncertain = 1
Yes = 2 ____

Drugs
No = 0
Uncertain = 1
Yes = 2 ____

Physical illness
No = 0
Uncertain = 1
Yes = 2 ____

ONSET

Gradual onset over several years
No = 0
Uncertain = 1
Yes = 2 ____

Stressful precipitant
No = 0
Uncertain = 1
Yes = 2 ____

All episodes associated with pregnancy/childbirth
No = 0
Yes = 1 ____

CHARACTERISTICS OF PSYCHOSIS

Best estimate of number of episodes, (50 if too numerous to count, if continuously ill count as one period)

How many times have you felt like that?

When did that start?
(et details)

When was the last time you had feelings like that?

How long did the longest time last for?

Have you felt like that recently?
For how long?

Number of episodes of symptoms ____ ____

Age at first symptom ____ ____ . ____

Age at last symptom ____ ____ . ____

Longest duration of an episode - weeks ____ ____ ____

Currently having symptoms
No = 0
Yes = 1 ____

Duration of current episode - weeks ____ ____ ____

PSYCHOSIS: TREATMENT/IMPAIRMENT

FOR ANY EPISODE OF PSYCHOSIS

What treatment did you have? Where?

Did you go to hospital?

Did it effect the way you managed your work/household tasks?
When was the first time that happened?

Determine for each episode the treatment (drugs, hospital etc) and impairment. Get the details so that these data can be checked in hospital notes (ask the patient whether you may speak to his Doctor about this).

FOR ANY EPISODE OF PSYCHOSIS

Ever hospitalized
No = 0
Yes = 1 ____

Somatic treatment (drugs, etc)
No = 0
Yes = 1 ____

Social functioning
Not affected = 0
Impaired = 1
Incapacitated = 2 ____

Age first hospital treatment
____ ____ . ____

Age first impaired
____ ____ . ____

SPECIFIC PSYCHOTIC SYMPTOMATOLOGY

For each symptom, indicate whether it occurred in conjunction with depression, mania, alcohol use, drug use, or at some other time. Ie: not in conjunction with episodes of the 4 types listed. To complete this section it is important to understand the DSM IV criteria for schizophrenia and schizo-affective disorder, and the differences between them. You should obtain sufficient data to arrive at the following questions, but do not repeat questions already asked in the screening section, or in initial probing. ALWAYS WRITE DOWN AN EXAMPLE.

When you were depressed/high/drinking/taking drugs, did you think that .....

Ideas/Delusions of Reference

That people would say things with a double meaning to you, or do things in a special way to convey a meaning? (have things been specially arranged? Do you think this was your imagination)?

? date onset ? Duration:

Persecutory delusions

Have you ever thought that anyone was deliberately causing you trouble, or trying to hurt you? (Is there some group involved?)

? date onset ? Duration :

Thought withdrawal/insertion

Have you ever felt that thoughts were put into your head that were not your own, or that thoughts were being taken away from you by some external force?

? date onset? Lasted at least one week

SPECIFIC PSYCHOTIC SYMPTOMATOLOGY

	Depression	Mania	Alcohol Drug Use		Other
Delusions of Reference Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Ideas of Reference Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Persecutory Delusions Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Thought Withdrawal/Insertion Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Lasting 1 Week No = 0 Yes = 2	____	____	____	____	____

Thought broadcasting

Have you ever felt that your thoughts were broadcast so other people knew what you were thinking?

? date onset ? duration ? lasted at least one week

Delusions of being controlled

Have you ever felt that you were being controlled by some force or power outside of yourself? (or that you were forced to make movements or say things without you willing it) or think things or impulses that were not your own?

? date onset ? duration ? lasted at least one week

Auditory hallucinations

The (sounds, voices) that you said you heard, did you hear them outside your head, or from inside your head. Could you hear what the voices were saying? How do you explain it?

? date onset ? duration ? lasted at least one week

Hallucinations commenting

Did the voice/voices comment on what you were doing or thinking?

? date onset ? duration ? lasted at least one week

Hallucinations conversing

Did you hear two or more voices talking to each other?

? date onset ? duration ? lasted at least one week

	Depression	Mania	Alcohol Drug Use	Other	
Thought broadcasting Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Lasting one week No = 0 Yes = 2	____	____	____	____	____
Delusions of being controlled Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Lasting one week No = 0 Yes = 2	____	____	____	____	____
Auditory hallucinations Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Lasting one week No = 0 Yes = 2	____	____	____	____	____
Hallucinations commenting Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Lasting one week No = 0 Yes = 2	____	____	____	____	____
Hallucinations conversing Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Lasting 1 Week No = 0 Yes = 2	____	____	____	____	____

SPECIFIC PSYCHOTIC SYMPTOMATOLOGY CONTINUED

Visual hallucinations

Those visions you told me about, what were they like?
Did you see them quite clearly?
What were you doing when you saw them?
Probe to distinguish from illusions.

? date onset ? Duration

Olfactory hallucinations

Have you ever noticed any strange or unusual smells that other people haven't noticed?

? date onset ? Duration

Somatic hallucinations

What about strange feelings in your body?

? date onset ? Duration

Definite thought disorder

Have people ever had trouble understanding what you were saying because your speech was mixed up, or because you didn't make sense?

? date onset ? lasted at least 1 week

	Depression	Mania	Alcohol Drug Use		Other
Visual Hallucinations Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Olfactory Hallucinations Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Somatic Hallucinations Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Definite thought disorder Absent = 0 Suspected = 1 Definite = 2	____	____	____	____	____
Lasting 1 week No = 0 Yes = 2	____	____	____	____	____

	Depression	Mania	Alcohol Drug Use	Other	
Multiple delusions No = 0 Yes = 2	____	____	____	____	____
Bizarre delusions No = 0 Yes = 2	____	____	____	____	____
Delusions other than persecutory No = 0 Yes = 2	____	____	____	____	____
Non-affective verbal hallucinations to subject No = 0 Yes = 2	____	____	____	____	____
Lasted one week No = 0 Yes = 2	____	____	____	____	____

CHARACTERISTICS OF PSYCHOTIC SYMPTOMATOLOGY

These data can be completed after the interview. HOWEVER, before leaving the section ensure you have sufficient data, particularly on: duration, the association of delusions and hallucinations, affective/non-affective phenomena.

? multiple delusions (see manual)

? multiple delusions lasted 1 week

? bizarre delusions (see manual)

? bizarre delusions lasted 1 week

? delusions other than persecutory or jealousy, lasting at least 1 week

? delusions of any type accompanied by hallucinations of any type for at least 1 week

? non-affective verbal hallucinations spoken to the subject

? these hallucinations last at least 1 week

? Non-affective hallucinations throughout the day for several days or intermittently for at least 1 week

? For at least 1 month

? For at least 6 months

? Any delusions or hallucinations other than typically depressive

? Lasting at least 1 week

? Lasting at least 1 month

? Preoccupation with delusion or hallucination (other than typically depressive ones) to the relative exclusion of other concerns

? Obvious catatonic motor behaviour (see manual)
(rate on observational data only)

	Depression	Mania	Alcohol Drug Use		Other
Non affective hallucinations for 1 week					
No = 0 Yes = 2	____	____	____	____	____
For 1 month					
No = 0 Yes = 2	____	____	____	____	____
For 6 months					
No = 0 Yes = 2	____	____	____	____	____
Delusions/hallucinations other than depressive					
No = 0 Yes = 2	____	____	____	____	____
For 1 week					
No = 0 Yes = 2	____	____	____	____	____
For 1 month					
No = 0 Yes = 2	____	____	____	____	____
Exclusive preoccupation with delusion or hallucination					
No = 0 Yes = 2	____	____	____	____	____
Catatonic motor behaviour					
No = 0 Yes = 2	____	____	____	____	____

? Hallucinations of any type throughout the day for several days, or intermittently for at least one week

? For at least one month

? For at least 6 months

	Depression	Mania	Alcohol Drug Use		Other
Any type of hallucination for 1 week No = 0 Yes = 2	____	____	____	____	____
For 1 month No = 0 Yes = 2	____	____	____	____	____
For 6 months No = 0 Yes = 2	____	____	____	____	____

upssect
unspecified psychosis: section entered
0 No
1 Yes ____

upspre
unspecified psychosis: DSM IV diagnosis - currently or previously
0 No ____
1 Previously
2 Currently
3 Both
8 Not applicable
9 Not known

upstype
type of psychotic disorder ____
1 Schizophrenia 2 Schizoaffective

upsage
unspecified psychosis: age of onset ____ ____ . ____ ____
(calculate months as a fraction ie 9 months = 0.75)

upstime
unspecified psychosis: time after accident for onset in months ____ ____
88 Not applicable 99 Not known

upsepi ____ ____
unspecified psychosis: # of episodes
88 Not applicable 99 Not known

upstrt
unspecified psychosis: treatment
0 No ____
1 Yes
8 Not applicable
9 Not known

upsmed
unspecified psychosis: medical condition
0 No ____
1 Yes
8 Not applicable
9 Not known

upsdur
unspecified psychosis: duration (weeks) ____ ____ ____
888 Not applicable 999 Not known

upspatt
unspecified psychosis: pattern for disorder ____
0 None
1 Continuous
2 Hovers around threshold
3 On/off

DRUG ABUSE AND DEPENDENCE

SCREENING QUESTIONS

Have you ever taken anything to improve your mood or to get high like pot, LSD, amphetamines, or heroin?

Have you ever taken sedatives like Valium or barbiturates?

ENTER DRUG SECTION:

IF THE SUBJECT HAS EVER TAKEN "HARD DRUGS." eg: solvents, LSD, cocaine, heroin, or other hard drugs.

OR YOU SUSPECT ANY FORM OF DRUG ABUSE OR DEPENDENCE

PROBE BRIEFLY IF : the subject admits to taking other drugs. This probing should elicit brief details of amount and frequency. If this suggests no difficulties you need not complete this section. For example, smoking pot in company or taking Valium at one or two stressful times only. HOWEVER, regular taking of either over a prolonged period would require entry into the section.

IF NO, GO TO EATING DISORDERS.

DRUG SECTION

You mentioned taking (substance); I'd like to check on some other drugs on my list here.

Have you taken cannabis, amphetamine or speed, diet pills, barbiturates, Valium, LSD, cocaine, crack, ecstasy, glue, or anything else like that? (ring drug; do not repeat names already asked)

Possible drug abuse or dependence
0 No 1 Yes ____

Ever taken
0 No 1 Yes

1 amphetamines
(speed, methedrine) ____

2 amylnitrite/butylnitrite
(poppers, amyl) ____

3 barbiturates
(downers) ____

4 benzodiazapines
(Valium, diazepam, tranquilizers) ____

5 cannabis
(marijuana, pot, dope) ____

6 cocaine ____

7 crack
(free base cocaine, rock) ____

8 ecstasy
(E, MDMA) ____

9 heroin
(smack) ____

10 LSD
(acid) ____

11 opium & opiates
(methadone, codeine) ____

12 PCP
(angel dust) ____

13 solvents & gases ____

14 Other ____

DRUG ABUSE AND DEPENDENCE

USE

How old were you when you first took x?

How much have you used it since then?

Have there been times when you stopped?
(Probe to establish the number of discrete periods when they subject took the drug)

How often did you take it?

For how many weeks did you take it as often as that?

How old were you when you last took x?

	Substance _____	Substance _____	Substance _____
Age first taken (years)	____ ____.____	____ ____.____	____ ____.____
Regular use for 1 month No = 0 Yes = 2	____	____	____
Remission of 1 year No = 0 Yes = 2	____	____	____
Number of episodes	____ ____ ____	____ ____ ____	____ ____ ____
Age last taken (years)	____ ____.____	____ ____.____	____ ____.____

II. PATTERN OF USE

Did you ever have any problems with x?
(Tell me some more about that)

Did you ever try to cut down? Why was that?

What happened when you cut down?

Did you get withdrawal symptoms?
(Tell me about those)
(Such as craving, anxiety, sleep problems, fits)
(Did you ever take x to stop these symptoms?)

Did you ever take too much, or an overdose?
What happened? How many times?

Did you ever stay high (or use the subject's words) for the whole day?
What symptoms did you have?

Did you ever have any strange experiences, such as the feeling people were out to get you?

Or times when you saw or heard things that were not really there?

	Substance _____		Substance _____		Substance _____	
Number of attempts to abstain	____	____	____	____	____	____
Craving No = 0 Yes = 2		____		____		____
Mental symptoms No = 0 Yes = 2		____		____		____
Sleep problems 0 = none 2 = yes, >1 hr lost		____		____		____
Any physical symptom 0 = none 2 = yes		____		____		____
Withdrawal delirium 0 = none 2 = yes		____		____		____
Withdrawal seizure 0 = no 2 = yes		____		____		____
Takes drug to relieve withdrawal symptoms (Number of times)	____ ____	____	____ ____	____	____ ____	____
Overdose (Number)	____	____	____	____	____	____
Continuous intoxication for 1 day 0 = No 1 = Once 2 = 2 or more		____		____		____
Delusional syndrome 0 = no 1 = once 2 = 2 or more		____		____		____
Hallucinatory syndrome 0 = No 1 = Once 2 = 2 or more		____		____		____

III. SOCIAL/PHYSICAL COMPLICATIONS

Did you have any problems at work/school? (Probe for social impairment/incapacitation) (When did that first happen?)

Or problems with your family or friends?

Or go for help .... or to hospital?

Or trouble with the police?

Or problems with your physical health?

IV TOLERANCE

Did you use the same amount now/after you stopped as when you started?

Did you find you didn't get as high when you used your usual amount?

III. SOCIAL/PHYSICAL COMPLICATIONS

Substance _____ Substance _____ Substance _____

Social impairment due to drug use ____ ____ ____

Age onset social imp/inc
(Years)
____ ____ . ____ ____ ____ . ____ ____ ____ . ____

Problems with family or friends
0 = no ____ ____ ____
2 = yes

Sought help because of drug use
0 = no ____ ____ ____
1 = dubious
2 = friend/family
3 = GP
4= specialist
5 = hospitalized

Took medication
0 = no ____ ____ ____
2 = yes

Legal difficulties
0 = none ____ ____ ____
1 = police contact only
2 = any conviction for drug use

Physical damage
0 = none ____ ____ ____
1 = possible
2 = definite, non life threatening
3 = life threatening (eg aids, liver damage)

Takes drug despite consequences
0 = none ____ ____ ____
1 = possible
2 = definite

IV TOLERANCE

Tolerance
0 = None ____ ____ ____
1 = Possible
2 = Definite

SUMMARY: FOR ALL SUBSTANCES

? Sought help

? Other suggested seek help

? Medication

? Hospitalized

? Social functioning

? Extent of use

? Age first problem

? Previous episode followed by remission (of 1 year)

? Age stopped used heavily (88 if used drug heavily in last 6 months)

? Year most severe episode commenced

? Number of episodes

	No	Yes	
Sought help from:			
Professional	0	1	____
Church	0	1	____
Friend	0	1	____
Other suggested seek help	0	1	____
Medication	0	1	____
Hospitalized	0	1	____

Social functioning ____
Not affected = 0
Impaired = 1
Incapacitated = 2

Extent of use ____
None = 0
Clinically insignificant, eg. occasional use of marijuana, or amphetamines to stay awake = 1
Some minor interference with normal functioning or cannot feel good without use of drug = 2
Drug use results in important modifications in his life, or often takes an addicting drug or has withdrawal symptoms = 3
Drug use results in major changes in his life or frequently takes an addicting drug (eg. hospitalized because of drug use) = 4
Drug use results in major disruption in his life (eg. major activities revolve around getting drugs) = 5

Age at first problem ____ ____.____

Episode followed by remission ____
No = 0
Yes = 1

Age stopped ____ ____.____

Most severe (year) ____ ____.____

Number of episodes ____ ____

SUMMARY FOR DRUG SECTION

dgtype1 _____ *dgtype2* _____ *dgtype3* _____

dguse

extent of drug use

0	None	1	Insignificant	2	Minor interference
3	Important modification	4	Major change	5	Disruption
8	Not applicable	9	Not known		

_____

dgsect

drugs: section entered

0	No
1	Yes

_____

Drug Abuse

dgabpre

drug abuse: DSM IV diagnosis - currently or previously

0	No	1	Previously	_____
2	Currently	3	Both	
8	Not applicable	9	Not known	

dgabage

drug abuse: age of onset _____ _____ . _____ _____

(calculate months as a fraction ie 9 months = 0.75)

dgabtime

drug abuse: time after accident for onset in months _____ _____

88	Not applicable
99	Not known

dgabepi _____ _____

drug abuse: # of episodes

88	Not applicable
99	Not known

dgabtrt

drug abuse: treatment

0	No	_____
1	Yes	
8	Not applicable	
9	Not known	

dgabmed

drug abuse: medical condition

0	No	_____
1	Yes	
8	Not applicable	
9	Not known	

dgabdur

drug abuse: duration (weeks) _____ _____ _____

888	Not applicable
999	Not known

dgabpatt

drug abuse: pattern for disorder _____

0	None	1	Continuous
2	Hovers around threshold	3	On/off

Drug Dependence

dgdeppre
drug dependence: DSM IV diagnosis - currently or previously
- 0 No
- 1 Previously
- 2 Currently
- 3 Both
- 8 Not applicable
- 9 Not known

dgdepage
drug dependence: age of onset
(calculate months as a fraction ie 9 months = 0.75)

dgdeptime
drug dependence: time after accident for onset in months
- 88 Not applicable
- 99 Not known

dgdepepi
drug dependence: # of episodes
- 88 Not applicable
- 99 Not known

dgdeptrt
drug dependence: treatment
- 0 No
- 1 Yes
- 8 Not applicable
- 9 Not known

dgdepmed
drug dependence: medical condition
- 0 No
- 1 Yes
- 8 Not applicable
- 9 Not known

dgdepdur
drug dependence: duration (weeks)
- 888 Not applicable
- 999 Not known

dgdeppat
drug dependence: pattern for disorder
- 0 None
- 1 Continuous
- 2 Hovers around threshold
- 3 On/off

EATING DISORDERS NB ADD QUESTIONS ABOUT PERIODS(23.4.95)

SCREENING QUESTIONS

(Note: if the subject affirms a screen, find out when this was most pronounced, and concentrate on this period)

Have you ever had any difficulties with eating?

NB Dep. - appetite poor/good, weight gain and loss

For example, have you ever been very concerned about food?

Have you ever ...

felt that food controls your life?

felt very aware of the calorie content of food?

avoided food with sugar in?

How much time did you spend dieting or thinking about food?

Have you ever gone on a diet?

(Have you ever lost a lot of weight? NB Dep.

What did you weigh at the start?

How much did you lose?

Over how long a time?

What did you eat?

Did you enjoy dieting?

What is your height?

Have you ever been very frightened of being overweight?

Have you ever been very concerned with having fat on your body?

What did you do?

Were you still frightened of being fat even after you had lost weight?

ENTER THE SECTION....

IF THE SUBJECT SCORES 2 OR MORE ON SCREENS

OR LOST MORE THAN FIFTEEN PERCENT OF USUAL BODY WEIGHT

OR YOU SUSPECT EATING DISORDER

IF NOT, GO TO BULIMIA.

NOTE: I: If the subject has had depressive, or psychotic episodes, inquire if these coincided with or were separate from episodes of eating disorders.

II: Many patients with bulimia nervosa have previously satisfied the diagnostic criteria for anorexia nervosa. If the screens suggest both disorders have been present, be sure to record the characteristics of each disorder in the relevant section.

EATING DISORDERS

SCREENING QUESTIONS

Preoccupation with food

No = 0

Preoccupied = absorbed in thoughts about food to the relative exclusion of other activities.

Over concern about food, calories or dieting = 1
Preoccupied with food, calories or dieting = 2
Severe preoccupation with food = 3

NB Depression

Loss of appetite 1 = mild 2 = clinically significant 3 = severe	0	1	2	3	____	0	1	2	3	____
Increased appetite As for loss of appetite.	0	1	2	3	____	0	1	2	3	____
Loss of weight 1 = 2-6 pounds lost 2 = more than 6 pounds 3=more than one stone	0	1	2	3	____	0	1	2	3	____
Weight gain As for weight loss	0	1	2	3	____	0	1	2	3	____

Weight at the start of the most severe period of weight loss

Kgs ____ ____

Amount of weight loss

Kgs ____ ____

Height (cms) ____ ____ ____

Fear of fatness

No = 0 ____
Occasional worries about being overweight = 1
Intense fear of being fat = 2
Marked, frequent fears of being fat = 3

Fear of fatness which did not diminish when weight loss had occurred

No = 0
Uncertain = 1
Yes = 2 ____

ANOREXIA NERVOSA/ ANOREXIC SYMPTOMS: CHARACTERISTICS

How old were you when that started?

How many times has have you felt like that?

(Has a past episode been followed by a remission of 2 months?

How long did the longest time last?

Have you been like that recently?

When was the worst time? How old were you then?

TREATMENT/IMPAIRMENT (most severe episode, or current/onset where appropriate)

Did you seek help from anyone like ....

A doctor or other professional?

A member of the Church?

A friend?

Or did someone suggest you get help?

Did you take any medication?

(If yes, get details of drug, amount, duration, and effects)

Did you have to stay in hospital?

Did/does it get in the way of your life?
How about things at work/school?
Has it effected your social life? Stopped you doing things?
How about getting on with other people?

Does it bother you?

How old were you when you first ..... (any of above)

Age at onset of first symptom ___ ___ . ___

Past episode followed by remission (of 2 months)
No = 0
Yes = 1 ___

Number of episodes ___ ___

Duration of longest episode
Weeks ___ ___ ___

Currently in episode
No = 0
Yes = 1 ___

Duration of current episode
Weeks ___ ___ ___

Sought help from:

Professional 0 1 ___

Church 0 1 ___

Friend 0 1 ___

Other suggested seek help 0 1 ___

Medication 0 1 ___

Hospitalized 0 1 ___

Social functioning
Not affected = 0
Impaired = 1
Incapacitated = 2 ___

Age of impairment/incapacitation ___ ___ . ___

ADD RATINGS OF EATING DISORDERS NOT OTHERWISE SPECIFIED

ANOREXIA: SYMPTOMS DURING MOST SEVERE EPISODE

I'd like to concentrate on the time when you lost that weight ....

Did you think that you were still fat, even when you'd lost weight?

(.... or when others said you were thin?)

(.... did you believe people when they said you were thin?)

When you lost that weight, did other people try to get you to eat?

What did you do? Did you refuse to eat?

Have you ever tried to lose weight or stop yourself putting on weight by making yourself sick, or taking medication?
(When? How often? What medication?)

... or by exercising a lot?

... or by fasting

Did you have any kind of physical illness at that time?

(if yes, get details of hospital name, investigations, what the Doctor said)

IN FEMALES: Did you have any problems with your periods at that time?

(if no, had you already had your first period?)

(if yes, how long did your periods stop for?)

NB Physical health - amenorrhea for 3 months.

Disturbed body image
No = 0
Doubtful = 1
Felt she was too fat but did recognise this might be incorrect = 2
Felt she was too fat, even when severely underweight, and did not feel that this idea was wrong = 3 ____

Refusal to eat
No = 0
Sometimes refused to eat sufficient food to maintain body weight, even when others tried to persuade her to eat = 1
Often refused to eat = 2 ____

Any attempts to lose weight by vomiting, laxatives or diuretics

	No	Yes	
Vomiting	0	1	____
Laxatives	0	1	____
Diuretics	0	1	____
Other drug	0	1	____
Excess exercise	0	1	____
Fasting	0	1	____

Weight loss not explained by physical cause
No = 0
Uncertain = 1
Yes = 2 ____

Amenorrhea for 3 months
No = 0
Yes = 1 ____

Nb Physical health
Amenorrhea for 3 months (0 = no, 1 = yes) ____

Duration of amenorrhea
Months ____ ____ ____

EATING DISORDERS: BULIMIC SYMPTOMS

Have you ever gone on an eating binge when you ate a very large amount of food in a short time?

(When? How often? How long do they last for?
Do you think the amount you ate was too much?
What happened afterwards?)

Have you ever tried to lose weight or stop yourself putting on weight by making yourself sick, or taking medication?
(When? How often? What medication?)

... or by exercising a lot?

... or by fasting

IF EITHER SCREEN POSITIVE COMPLETE THIS SECTION.

IF NOT, GO TO PHYSICAL HEALTH.

Binges

(Bouts of eating which the subject regards as excessive, usually lasting less than 2 hours)

None = 0
Suspected = 1
Definite = 2

_____

Number of binges (ever)

None = 0
One = 1
Two or three = 2
Four or more = 3

_____

Any attempts to lose weight by vomiting, laxatives or diuretics

	No	Yes	
Vomiting	0	1	_____
Laxatives	0	1	_____
Diuretics	0	1	_____
Other drug	0	1	_____
Excess exercise	0	1	_____
Fasting	0	1	_____

Number of attempts to lose weight by:

Vomiting	_____	_____
Laxatives	_____	_____
Diuretics	_____	_____
Other Drug	_____	_____
Excess exercise	_____	_____
Fasting	_____	_____

BULIMIA/BULIMIC SYMPTOMS: CHARACTERISTICS

How old were you when that started?

How many times has have you felt like that?

Has a past episode been followed by a remission of 2 months?

How long did the longest time last?

Have you been like that recently?

When was the worst time? How old were you then?

TREATMENT AND IMPAIRMENT

Did you seek help from anyone like ....

A Doctor or other professional?

A member of the Church?

A friend?

Or did someone suggest you seek help?

Did you take any medication?

(If yes, get details of drug, amount, duration, effects)

Did you have to stay in hospital?

Did/does it get in the way of your life?
How about things at work/school?
Has it effected your social life? Stopped you doing things?
How about getting on with other people?

Does it bother you?

How old were you when you first ..... (any of above)

Age at onset of first symptom ____ ____ . ____

Past episode followed by remission
(of 2 months)
No = 0
Yes = 1 ____

Number of episodes ____ ____ ____

Duration of longest episode
Weeks ____ ____ ____

Currently in episode
No = 0
Yes = 1 ____

Duration of current episode
Weeks ____ ____ ____

TREATMENT AND IMPAIRMENT

Sought help from:

	No	Yes	
A professional	0	1	____
Church	0	1	____
Friend	0	1	____
Other suggested seek help	0	1	____
Medication	0	1	____
Hospitalized	0	1	____

Social functioning
Not affected = 0
Impaired = 1
Incapacitated = 2 ____

Age of impairment/incapacitation ____ ____ . ____

BULIMIA/BULIMIC SYMPTOMS DURING MOST SEVERE EPISODE

I'd like you to concentrate on that period when you were eating a lot

When you were eating like that, how often would you binge in a week?
Did this go on for a few months?

What sort of food did you eat during a typical bout?

Did you feel your eating was out of control?

Did you eat alone?
(Where? How often?)

What happened at the end of one of these eating bouts?
(obtain an account)

Did you have to stop because of pain?

.... **go to sleep?**

.... **make yourself sick?**

.... **or did someone interrupt you**

How did you feel in yourself after one of these bouts?
Did you feel sad, or angry with yourself?

What happened to your weight when you were binging?
Did it change much? How much?

How much influence did your weight or body shape have on the way you felt about yourself?

Did you have any kind of physical illness at that time?
(if yes, get details of the hospital name, investigations, and what the Doctor said)

Two or more binges per week for three months or more
No = 0
Suspected = 1
Yes = 2 ____

Consumption of high calorie, easily ingested food
No = 0
Uncertain = 1
Yes = 2 ____

Loss of control during most binges
No = 0
Uncertain = 1
Yes = 2 ____

Inconspicuous ingestion of food
No = 0
Uncertain = 1
Yes = 2 ____

Binge terminated by:

	No	Yes	
Abdominal pain	0	1	____
Sleep	0	1	____
Vomiting	0	1	____
Interruption	0	1	____

Mood following binge
No change = 1
Self disgust = 2
Depressed = 3 ____

Frequent weight fluctuations of more than ten pounds
No = 0
Uncertain = 1
Yes = 2 ____

Undue influence of body shape & weight
None = 0
Some emphasis on shape and weight = 1
Self evaluation unduly influenced by body shape and weight = 2 ____

Weight loss not explained by physical cause
No = 0
Uncertain = 1
Yes = 2 ____

SUMMARY FOR EATING DISORDER

eatsect

eating disorders: section entered
0 No
1 Yes

Anorexia

anorpre
anorexia: DSM IV diagnosis - currently or previously
0 No
1 Previously
2 Currently
3 Both
8 Not applicable
9 Not known

anorage
anorexia: age of onset
(calculate months as a fraction ie 9 months = 0.75)

anortime
anorexia: time after accident for onset in months
88 Not applicable
99 Not known

anorepi
anorexia: # of episodes
88 Not applicable
99 Not known

anortrt
anorexia: treatment
0 No
1 Yes
8 Not applicable
9 Not known

anormed
anorexia: medical condition
0 No
1 Yes
8 Not applicable
9 Not known

anordur
anorexia: duration (weeks)
888 Not applicable
999 Not known

anorpat
anorexia: pattern for disorder
0 None
1 Continuous
2 Hovers around threshold
3 On/off

Bulimia

bulpre
bulimia: DSM IV diagnosis - currently or previously ____

0	No
1	Previously
2	Currently
3	Both
8	Not applicable
9	Not known

bulage
bulimia: age of onset ____ ____ ____ ____
(calculate months as a fraction ie 9 months = 0.75)

bultime
bulimia: time after accident for onset in months ____ ____

88	Not applicable
99	Not known

bulepi
bulimia: # of episodes ____ ____

88	Not applicable
99	Not known

bultrt
bulimia: treatment ____

0	No
1	Yes
8	Not applicable
9	Not known

bulmed
bulimia: medical condition ____

0	No
1	Yes
8	Not applicable
9	Not known

buldur
bulimia: duration (weeks) ____ ____ ____

888	Not applicable
999	Not known

bulpat
bulimia: pattern for disorder ____

0	None
1	Continuous
2	Hovers around threshold
3	On/off

OTHER DYSPHORIC SYMPTOMS

Finally, I'd like to check on some other symptoms.
...apart from the times we've talked about

Has there ever been a time when you had the feeling you had lost a lot of energy?
Or get tired more easily
Your physical energy to do things
How many activities did it affect?

NB Depression

Have you ever had any trouble sleeping?
(if yes, get details)

NB CAPS; GAD; Depression

Have you ever lost weight when you were not dieting?
How much?

NB Depression

Has there ever been a time when you felt very pessimistic or hopeless?
How hopeless did you feel?

NB CAPS; Depression

Has there ever been a time when you felt a failure or very worthless?
How often did you feel like that?

If any of the above are positive, get the details: date, duration, associated symptoms, impairment. You may find these form part of a diagnosis, in which case proceed to the relevant section. If not, take notes and establish the circumstances surrounding these symptoms.

Subjective loss of energy

Note: rate as present even if due to medication. Do not confuse with loss of interest.

None = 0
Mild loss of energy of doubtful significance = 1
Definite loss of energy moderate intensity = 2
Severe loss, involving most activities and lasting for most of the day = 3

NB Depression

Insomnia

None = 0
Occasional infrequent difficulty of doubtful significance = 1
One or more hours lost for at least 4 days a week lasting 2 weeks = 2
Two or more hours lost for at least 4 days a week lasting 2 weeks = 3

NB CAPS, GAD, Depression

Weight loss due to loss of appetite

None = 0
Less than 6 pounds = 1
7 to 14 pounds = 2
More than 14 pounds = 3

NB Depression

Hopelessness

None= 0
Mild discouragement about the future = 1
Definite hopelessness still has some degree of hope = 2
Severe, has given up all hope = 3

NB CAPS, Depression

Negative evaluation of self

None = 0
Occasionally feels a little inadequate = 1
Often feels like a failure = 2
Severe pervasive feelings of worthlessness = 3

ADJUSTMENT DISORDER
(Use this section as a post interview checklist)

Emotional or behavioural symptoms in response to stressor(s) ____
No 0
Yes 1

Onset within three months of stressor(s) ____
No 0
Yes 1

Remission 6 months after termination of stressor or its consequences ____
No 0
Yes 1

Marked sistress in excess of expectations for stressor ____
No 0
Yes 1

Significant impairment in social, occupational or academic functioning ____
No 0
Yes 1

Disturbance does not meet criteria for any other Axis 1 disorder ____
No 0
Yes 1

Disturbance is not an exacerbation of apreexisting disorder ____
No 0
Yes 1

Symptoms do not represent bereavment ____
No 0
Yes 1

SUMMARY FOR ADJUSTMENT DISORDER

adjsect
adjustment disorder: section entered
0 No
1 Yes

adjpre
adjustment disorder: DSM IV diagnosis - currently or previously
0 No
1 Previously
2 Currently
3 Both
8 Not applicable
9 Not known

adjage
adjustment disorder: age of onset
(calculate months as a fraction ie 9 months = 0.75)

adjtime
adjustment disorder: time after accident for onset in months
88 Not applicable
99 Not known

adjepi
adjustment disorder: # of episodes
88 Not applicable
99 Not known

adjtrt
adjustment disorder: treatment
0 No
1 Yes
8 Not applicable
9 Not known

adjmed
adjustment disorder: medical condition
0 No
1 Yes
8 Not applicable
9 Not known

adjdur
adjustment disorder: duration (weeks)
888 Not applicable
999 Not known

adjpat
adjustment disorder: pattern for disorder
0 None
1 Continuous
2 Hovers around threshold
3 On/off

POSTTRAUMATIC STRESS DISORDER. The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor with a duration of more than 1 month. In contrast, in Adjustment Disorder, the stressor can be of any severity. In Acute Stress Disorder, anxiety and dissociative features develop within one month after exposure to an extreme traumatic stressor.

There are 5 criteria.

I. The person has been exposed to a traumatic event in which s/he experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. And the person's response involved intense fear, helplessness, or horror.

Has anything terrible or traumatic ever happened to you? Have you ever witnessed a life-threatening event?

Can you describe your response to the trauma? (Check to see that person's response was severe,involving intense fear, helplessness, or horror with a duration of at least one month.)

If 'YES':

II. The traumatic event is persistently reexperienced in one (or more) of the following ways:

Have you continued to reexperience the traumatic event? In what way?

---recurrent and intrusive distressing recollections of the event, including images,thoughts, or perceptions.

---recurrent distressing dreams of the event.

---acting or feeling as if the traumatic event were recurring (i.e., a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

---intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

---physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

III. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma).

In response to the trauma have you experienced any of the following:

---Have you tried to avoid thoughts, feelings, or conversations associated with the trauma?

---Have you avoided activities, places,or people that arouse recollections of the trauma?

---Were you unable to recall an important aspect of the trauma?

---Did your interest or participation in significant activities markedly diminish?

---Did you experience a feeling of detachment or estrangement from others?

---Was your range of emotions (affect) restricted (e.g., unable to have loving feelings)?

---Did you have a sense of a foreshortened future (e.g., did not expect to have a career, get married, have children, or live a normal life span)?

Need 3 or more of the above symptoms.

IV. Persistent symptoms of increased arousal (not present before the trauma).

---Did you have trouble falling or staying asleep?

---Were you irritable or did you have outbursts of anger?

---Did you have difficulty concentrating?

---Were you hypervigilant?

---Were you easily startled (exaggerated startle response).

Need 2 or more of the above symptoms.

V. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Did your response to the trauma affect your functioning in any way - socially, your family, your work?

Has met the five criteria for PTSD.....Yes
Duration of longest episode in weeks.....___
Currently in an episode.....___
If yes, duration of current episode in weeks.....___

OTHER PSYCHIATRIC DISORDER

Apart from the things we've talked about, have you had any other problems with your nervous health?

DESCRIBE HERE OTHER DISORDERS THAT ARE NOT COVERED IN THE MAIN INTERVIEW.

E.G.: I: A specific disorder (eg: an organic brain syndrome)

II: A recognized psychiatric symptom (eg: depersonalization, insomnia, conversion reaction, amnesia)

CHARACTERISTICS

? Age at onset

? Duration (in weeks) of longest episode

? Currently in an episode

? Past episode followed by remission

TREATMENT/IMPAIRMENT

? Sought help from:

A professional

Member of the Church

A friend

? Someone suggested get help

? Medication

? Hospitalized

? Had impaired functioning at home, work or school

AT THE END OF THE INTERVIEW:

Spend a few minutes checking that you have covered at least the screening questions for each section (use the contents page as a checklist).

Have you made any assumptions that you haven't verified?

Have you enough information to make a diagnosis for DSM from the sections that you entered?

Think about the rating periods for the AD-APFA.

Now might be a good time to take a break!

APPENDIX 4.2. THE STRUCTURED CLINICAL INTERVIEW FOR DSM-III-R (SCID-II) INTERVIEW PROTOCOL AND RATING SHEET

STRUCTURED CLINICAL INTERVIEW

FOR DSM-III-R

PERSONALITY DISORDERS

SCID-II

INTERVIEWER _____

PATIENT _____

RECORD # _____

Manufactured in the United States of America

90 91 92 93 5 4 3 2 1

ISBN 0-88048-414-4

Also Available

User's Guide for the Structured Clinical Interview for DSM-III-R (SCID) (Version 1.0)

Complete background information and instructions for all versions of the SCID instruments (order number 8410)

Structured Clinical Interview for DSM-III-R: Patient Edition (SCID-P) (Version 1.0)

Available in lots of 10 one-use copies of the instrument (order number 8411)

Structured Clinical Interview for DSM-III-R: Patient Edition (with Psychotic Screen) (SCID-P with Psychotic Screen) (Version 1.0)

Available in lots of 10 one-use copies of the instrument (order number 8412)

Structured Clinical Interview for DSM-III-R: Nonpatient Edition (SCID-NP) (Version 1.0)

Available in lots of 10 one-use copies of the instrument (order number 8413)

STRUCTURED CLINICAL INTERVIEW FOR DSM-III-R PERSONALITY DISORDERS

SCID-II (Version 1.0)

Robert L. Spitzer, M.D.; Janet B. W. Williams, D.S.W.;
Miriam Gibbon, M.S.W.; and Michael B. First, M.D.

20
01-02

tudy: _____ Study No.: — — — — 03-06

ubject: _____ I.D. No.: — — — — 07-10

ater: _____ Rater No.: — — — 11-13

Rater is: Interviewer 1 14
Observer 2

Date of interview: — — — — — — 15-20
Mo. Day Year

Evaluation: Initial 1 21
Reevaluation 2

Sources of information (check all that apply): 22

__ Subject 23
__ Family/friends/associates 24
__ Health professional/chart/referral note 25
__ SCID-II Personality Questionnaire

__ Consultation with: _____ 26

Form No. 04 79-80*

Edited and checked by: _____ Date: _____

*Keypunch: Duplicate on all cards.

The development of the SCID has been supported in part by NIMH Contract #278-83-0007(DB) and NIMH Grant #1 R01 MH40511-01.

For citation: Spitzer Robert L., Williams Janet B. W., Gibbon Miriam, First Michael B.: "Structured Clinical Interview for DSM-III-R—Personality Disorders (SCID-II, Version 1.0)." Washington, DC, American Psychiatric Press, 1990.

SCID-II SUMMARY SCORE SHEET

Overall quality and completeness of information: 1 = poor, 2 = fair, 3 = good, 4 = excellent 27

Duration of interview (minutes) ___ ___ ___ 28-30

PERSONALITY DISORDER		DIAGNOSTIC INDEX					CURRENT SEVERITY (past year)			
		INADEQUATE INFO.	ABSENT	SUB-THRESHOLD	THRESHOLD		MILD	MODERATE	SEVERE	
01	Avoidant	?	1	2	|3|	⟶	1	2	3	31 32
02	Dependent	?	1	2	|3|	⟶	1	2	3	33 34
03	Obsessive-Compulsive	?	1	2	|3|	⟶	1	2	3	35 36
04	Passive Aggressive	?	1	2	|3|	⟶	1	2	3	37 38
05	Self-Defeating	?	1	2	|3|	⟶	1	2	3	39 40
06	Paranoid	?	1	2	|3|	⟶	1	2	3	41 42
07	Schizotypal	?	1	2	|3|	⟶	1	2	3	43 44
08	Schizoid	?	1	2	|3|	⟶	1	2	3	45 46
09	Histrionic	?	1	2	|3|	⟶	1	2	3	47 48
10	Narcissistic	?	1	2	|3|	⟶	1	2	3	49 50
11	Borderlir :	?	1	2	|3|	⟶	1	2	3	51 52
12	Antisocial	?	1	2	|3|	⟶	1	2	3	53 54
13	NOS	?	1	2	|3|	⟶	1	2	3	55 56

PRINCIPAL AXIS II DIAGNOSIS (i.e., the Personality Disorder that is—or should be—the main focus of clinical attention)

Enter code number from left of diagnosis above: ___ ___ 57-58
Note: Enter 99 if no Axis II disorder.

OVERVIEW FOR PERSONALITY DISORDERS

Now I am going to ask you some questions about the kind of person you are, that is, how you have generally felt or behaved.

IF A CIRCUMSCRIBED OR EPISODIC AXIS I DISORDER HAS BEEN PRESENT: I know that there have been times when you have been (AXIS I SXS). I am not talking about those times and you should try to think of how you *usually* are when you are *not* (AXIS I SXS). Do you have any questions about this?

How would you describe yourself as a person (before AXIS I SXS)?

IF CAN'T ANSWER, MOVE ON.

How do you think other people would describe you as a person (before AXIS I SXS)?

Who have been the important people in your life? (IF MENTIONS ONLY FAMILY: What about friends?)

How have you gotten along with them?

Do you think that the usual way that you react to things or behave with people has caused you problems with anyone? (At home? At school? At work?) (In what way?)

What kinds of things have you done that other people might have found annoying?

How do you spend your free time?

If you could change your personality in some ways, how would you want to be different?

IF QUESTIONNAIRE HAS BEEN COMPLETED:

Now I want to go over the questions you said "yes" to on the questionnaire.

IF QUESTIONNAIRE HAS NOT BEEN COMPLETED:

Now I want to ask you some more specific questions

AVOIDANT PERSONALITY DISORDER	AVOIDANT PERSONALITY DISORDER CRITERIA				
	A pervasive pattern of social discomfort, fear of negative evaluation, and timidity, beginning by early adulthood and present in a variety of contexts, as indicated by at least 4 of the following:				
1. You've said that your feelings are [*Are your feelings*] more easily hurt than most people's if someone criticizes you or disapproves of something you say or do. Are you easily hurt by even minor criticism or disapproval?	(1) is easily hurt by criticism or disapproval (Also in Dependent) 3 = many examples of being hurt by minimal criticism or disapproval, or one example and subject reports it happens frequently	?	1	2	3
2. You've said that there are [*Are there*] very few people that you are really close to outside of your immediate family. How many close friends do you have (people you can confide in)?	(2) has no close friends or confidants (or only one) other than first-degree relatives (Also in Schizoid and Schizotypal) [Note: spouse can count as confidant] 3 = none or only one	?	1	2	3
3. You've said that [*Do*] you avoid getting involved with people unless you are certain they will like you. If you don't know whether someone likes you, would you ever make the first move?	(3) is unwilling to get involved with people unless certain of being liked 3 = almost never takes the initiative in becoming involved in a social relationship	?	1	2	3
4. You've said that [*Do*] you avoid social situations in which you might have to talk with other people. Give me some examples.	(4) avoids social or occupational activities that involve significant interpersonal contact, e.g., refuses a promotion that will increase social demands 3 = usually avoids social or occupational situations in which reciprocal conversation is expected	?	1	2	3
5. You've said that you [*Have you*] avoided jobs or assignments that involved having to deal with a lot of people. Give me some examples. (Have you ever refused a promotion because it would involve dealing with more people than you would be comfortable with?)					
6. You've said that you're [*Are you*] often quiet in social situations because you're afraid of saying the wrong thing. Give me some examples. (What are you afraid will happen? Do others consider you a quiet person?)	(5) is reticent in social situations because of a fear of saying something inappropriate or foolish, or of being unable to answer a question 3 = acknowledges being almost always reticent with people (other than close friends)	?	1	2	3

?= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

7. You've said that you've [*Have you*] often been afraid that you might look nervous or tense, or might cry or blush in front of other people.

   Tell me more about that.

   (Do you avoid situations in which you might look nervous or tense or reveal your emotions?)

(6) fears being embarrassed by blushing, crying, or showing signs of anxiety in front of other people

3 = acknowledges frequent fears that others will notice signs of anxiety or crying or blushing

? 1 2 3 64

8. You've said that [*Do*] a lot of things seem dangerous or difficult to you that do not seem that way to most people.

   What kinds of things?

   (Do you avoid doing things that are outside of your usual routine?)

(7) exaggerates the potential difficulties, physical dangers, or risks involved in doing something ordinary but outside of his or her usual routine, e.g., may cancel social plans at the last minute because she anticipates being exhausted by the effort of getting there

3 = several examples of avoiding activities that most others consider safe or requiring little effort

? 1 2 3 65

AT LEAST FOUR SXS ARE CODED "3"

1 3 66

Avoidant PD

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

DEPENDENT PERSONALITY DISORDER	DEPENDENT PERSONALITY DISORDER CRITERIA				
	A pervasive pattern of dependent and submissive behavior, beginning by early adulthood and present in a variety of contexts, as indicated by at least 5 of the following:				
9. You've said that [*Do*] you need a lot of advice or reassurance from others before you can make everyday decisions. Can you give me some examples of the kinds of decisions you would seek advice or reassurance about? (Does this happen most days?)	(1) is unable to make everyday decisions without an excessive amount of advice or reassurance from others 3 = acknowledges that this occurs most days	?	1	2	3
10. You've said that you have [*Have you*] allowed other people to make very important decisions for you. Give me examples of some specific decisions you've let other people make for you, more than just getting their advice. (Has this happened with MOST of your important life decisions?)	(2) allows others to make most of his or her important decisions, e.g., where to live, what job to take [Note: Do not include merely getting advice from others or subculturally expected behavior] 3 = several examples	?	1	2	3
11. You've said that [*Do*] you often agree with people even when you think they are wrong. Give me some examples of when you've done that. (What are you afraid will happen if you disagree? Do you almost always do that?)	(3) agrees with people even when he or she believes they are wrong, because of fear of being rejected [Note: Not just being silent] 3 = several examples or acknowledges trait	?	1	2	3
12. You've said [*Do*] you find it hard to start or work on tasks when there is no one to help you. Give me some examples. (Do you find that you have trouble taking the initiative? Do you almost always try to avoid working on your own?)	(4) has difficulty initiating projects or doing things on his or her own 3 = acknowledges almost always trying to avoid starting things or working independently, and at least one example	?	1	2	3

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

13. You've said that you have [*Have you*] often done unpleasant or demeaning things to get other people to like you.

    Give me some examples of these kind of things.

    (Did you offer or volunteer to do those things? Have you often done this?)

(5) volunteers to do things that are unpleasant or demeaning in order to get other people to like him or her ? 1 2 3

[Note: Do not include behavior intended to achieve goals other than being liked, such as job advancement]

3 = several examples or acknowledges that this happens often

14. You've said that [*Do*] you generally prefer *not* to be by yourself.

    Why is that?

15. You've said that [*Do*] you often do things to avoid being alone.

    What kinds of things do you do to avoid being alone?

    (How often?)

(6) feels uncomfortable or helpless when alone, or goes to great lengths to avoid being alone ? 1 2 3

3 = either acknowledges often being distressed when alone or goes to considerable lengths to avoid being alone.

16. You've said that you have [*Have you ever*] felt helpless or devastated when a close relationship ended.

    What was that like?

    (Have you reacted this way most of the time when close relationships have ended?)

(7) feels devastated or helpless when close relationships end ? 1 2 3

3 = acknowledges this happens when most close relationships end

17. You've said that [*Do*] you worry a lot about people that you care about leaving you.

    Are there often times when you keep worrying about this?

(8) is frequently preoccupied with fears of being abandoned ? 1 2 3

3 = reports that he or she keeps worrying about being abandoned

SEE AVOIDANT #1 (p. 1)

(9) is easily hurt by criticism or disapproval (Also in Avoidant) ? 1 2 3

AT LEAST FIVE SXS ARE CODED "3" 1 3

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

OBSESSIVE COMPULSIVE PERSONALITY DISORDER

	OBSESSIVE COMPULSIVE PERSONALITY DISORDER CRITERIA					
	A pervasive pattern of perfectionism and inflexibility, beginning by early adulthood and present in a variety of contexts, as indicated by at least 5 of the following:					
18. You've said that [*Do*] you have trouble finishing jobs because you spend so much time trying to get things exactly right. Give me some examples. (How often does this happen?)	(1) perfectionism that interferes with task completion, e.g., inability to complete a project because own overly strict standards are not met 3 = several examples of tasks not completed or significantly delayed because of perfectionism	?	1	2	3	16
19. You've said that you are [*Are you*] the kind of person who focuses on details, order, and organization, or who likes to make lists and schedules. Give me some examples. (Do you sometimes get so caught up with (EXAMPLES) that you lose sight of what you are trying to accomplish?) (Does this happen often?)	(2) preoccupation with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost 3 = several examples or acknowledges trait	?	1	2	3	17
20. You've said that [*Do*] you sometimes insist that other people do things exactly the way you want. Give me some examples. (IF UNREASONABLE: Does this happen often?)	(3) unreasonable insistence that others submit to exactly his or her way of doing things. OR unreasonable reluctance to allow others to do things because of the conviction that they will not do them correctly 3 = at least one example and acknowledges that often happens	?	1	2	3	18
21. You've said that [*Do*] you sometimes do things yourself because you know that no one else will do them exactly right. Give me some examples. (IF UNREASONABLE: Does this happen often?)						

?= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

22. You've said that you or your family feels that you [*Are you or does your family feel that you*] are so devoted to work (or school) that you have no time left for other people or for just having fun.

    Tell me about it.

    (How much time do you have left for other things? Are you usually this way?)

(4) excessive devotion to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)

[Note: Also not accounted for by temporary job requirements]

3 = acknowledges trait or is reported by informants

? 1 2 3

23. You've said that [*Do*] you sometimes have trouble making decisions because you can't make up your mind about what to do or how to do it.

    Give me some examples of that.

    (Does that happen often? Is that because you can't make decisions without other people's advice?)

(5) indecisiveness: decision-making is either avoided, postponed, or protracted, e.g., the person cannot get assignments done on time because of ruminating about priorities (DO NOT INCLUDE IF INDECISIVENESS IS DUE TO EXCESSIVE NEED FOR ADVICE OR REASSURANCE FROM OTHERS)

3 = several examples or acknowledges often being indecisive

? 1 2 3

24. You've said that [*Do*] you have higher standards than most people about what is right and what is wrong.

    Give me some examples of your high standards.

    (Have people ever told you that you are too rigid about what you think is right or wrong?)

(6) overconscientiousness, scrupulousness, and inflexibility about matters of morality, ethics, or values (not accounted for by cultural or religious identification)

3 = acknowledges trait or gives several examples of holding self or others to rigidly high moral standards

? 1 2 3

25. You've said that [*Do*] you often get angry at other people for breaking rules.

    What kinds of rules?

26. You've said that people have [*Have people*] complained that you are not affectionate enough.

    Tell me more about that.

    (Are you the kind of person who rarely hugs or kisses someone you care about, or who rarely shows them how much you care?)

(7) restricted expression of affection

3 = acknowledges hardly ever showing tender feelings

? 1 2 3

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

27. You've said that [*Do*] you rarely give presents, volunteer time, or do favors for other people.

    Tell me about it.

    (Do some people consider you stingy?)

(8) lack of generosity in giving time, money, or gifts when no personal gain is likely to result

3 = much more than most people

? 1 2 3 23

28. You've said that [*Do*] you have trouble throwing things out because they might come in handy some day.

    Give me some examples of things that you're unable to throw out.

    (How cluttered does your place get because you don't throw things out?)

(9) inability to discard worn out or worthless objects even when they have no sentimental value

3 = acknowledges that this trait results in a cluttered environment

? 1 2 3 24

AT LEAST FIVE SXS ARE CODED "3" 1 3 25

Obsessive Compulsive P.D.

?= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

PASSIVE AGGRESSIVE PERSONALITY DISORDER

	PASSIVE AGGRESSIVE PERSONALITY DISORDER CRITERIA					
	A pervasive pattern of passive resistance to demands for adequate social and occupational performance, beginning by early adulthood and present in a variety of contexts, as indicated by at least 5 of the following:					
29. You've said that [*Do*] you often put off doing things that people ask you to do until the last minute. Can you give me some examples of this? (Do you often end up NOT getting these things done on time?)	(1) procrastinates, i.e., puts off things that need to be done so that deadlines are not met 3 = acknowledges often procrastinating so that deadlines are not met when doing tasks required by others	?	1	2	3	26
30. You've said that you are [*Are you*] the kind of person who gets irritable or sulky if someone asks you to do something you don't want to do. Give me some examples of this. (Are people often sorry they asked you to do something because of the expression on your face or because you give them a hard time?)	(2) becomes sulky, irritable, or argumentative when asked to do something he or she does not want to do 3 = at least one example and acknowledges trait	?	1	2	3	27
31. You've said that you are [*Are you*] the kind of person who works very slowly or who does a bad job when asked to do something that you really don't want to do. Give me some examples of this.	(3) seems to work deliberately slowly or do a bad job on tasks that he or she really does not want to do 3 = several examples or one example and acknowledges trait	?	1	2	3	28
32. You've said that [*Do*] people often make unreasonable demands on you. Give me some examples. (Has this happened with other people?)	(4) protests, without justification, that others make unreasonable demands on him or her 3 = several examples of unjustified protests	?	1	2	3	29
33. You've said that [*Do*] you tend to "forget" to do things you are supposed to do if you really don't want to do them. Give me some examples of this.	(5) avoids obligations by claiming to have "forgotten" 3 = several examples or one example and acknowledges trait	?	1	2	3	30

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

34. You've said that [*Do*] you often think you're doing a better job than others give you credit for.

    Tell me more about that.

(6) believes that he or she is doing a much better job than others think he or she is doing

3 = several examples or one example and acknowledges trait

? 1 2 3 31

35. You've said that it annoys [*Does it annoy*] you when people make suggestions about how you could get more work done.

    Give me some examples.

(7) resents useful suggestions from others as to how he or she could be more productive

3 = several examples of resenting apparently useful suggestions or one example and acknowledges trait

? 1 2 3 32

36. You've said that people have [*Have people*] complained that you were holding them up by not doing your share of a job.

    Give me some specific examples of this.

(8) obstructs the efforts of others by failing to do his or her share of the work

3 = several examples or one example and acknowledges trait

? 1 2 3 33

37. You've said that you [*Do you*] often find that the people who are in charge of things (such as your boss or teachers) do not deserve your respect.

    Tell me about that.

    (Have you had bosses or teachers that you did respect?)

(9) unreasonably criticizes or scorns people in positions of authority

3 = "unreasonable" is indicated by hardly ever having respect for people in authority

? 1 2 3 34

AT LEAST FIVE SXS ARE CODED "3" 1 3 35

Passive Aggres Sx = 3

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

	SELF-DEFEATING PERSONALITY DISORDER CRITERIA					
	A pervasive pattern of self-defeating behavior, beginning by early adulthood and present in a variety of contexts. The individual may often avoid or undermine pleasurable experiences, be drawn to situations or relationships in which he or she will suffer, and prevent others from helping him or her, as indicated by at least 5 of the following: NOTE: A RATING OF "2" OR "3" REQUIRES EXAMPLES OF BEHAVIOR THAT DID NOT OCCUR ONLY WHEN DEPRESSED OR IN RESPONSE TO, OR IN ORDER TO AVOID, PHYSICAL, SEXUAL, OR PSYCHOLOGICAL ABUSE.					
38. You've said that you have [*Have you*] chosen a friend or lover who has taken advantage of you or let you down. Tell me about it. (Have you had other relationships like that?)	(1) chooses persons and situations that lead to his or her disappointment, failure, or mistreatment, even when better options are clearly available to him or her 3 = several (or one prolonged, i.e., lasting at least five years) relationships or situations	?	1	2	3	36
39. You've said that you have [*Have you*] sometimes gotten into bad situations at work or at school where you wound up being taken advantage of. Tell me about it. (How often has this happened?)						
40. You've said that [*Do*] you often refuse help from other people because you don't want to bother them. Give me examples of the kind of help you've refused.	(2) rejects or renders ineffective the attempts of others to help him or her 3 = often rejects help to avoid bothering other people, or several examples of sabotaging help	?	1	2	3	37
41. You've said that when people try to help you [*When people try to help you, do*] you make it hard for them. Describe how that happens. (Does that happen often?)						

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

42	You've said that when you are successful, you feel depressed or feel like you don't deserve it, or that you do something to spoil the success. [*When you are successful, do you feel depressed or like you don't deserve it, or do you do something to spoil the success?*] Give me some examples of this.	(3) following positive personal events (e.g., new achievement), responds with depression, guilt, or a behavior that brings about pain (e.g., an accident) 3 = several examples or one example and acknowledges trait	?	1	2	3	38
43.	You've said that you [*Do you*] often say or do things that make other people angry or upset with you. Give me some examples of this. (How do you feel when this happens?)	(4) incites angry or rejecting responses from others and then feels hurt, defeated, or humiliated (e.g., makes fun of spouse in public, provoking an angry retort, then feels devastated) 3 = several examples or one example and acknowledges trait	?	1	2	3	39
44.	You've said that [*Do*] you often turn down the chance to do things that you really enjoy. Give me some examples. (Does this happen often?)	(5) turns down opportunities for pleasure or is reluctant to acknowledge enjoying himself or herself (despite having adequate social skills and the capacity for pleasure) 3 = several examples or one example and acknowledges trait	?	1	2	3	40
45.	You've said that you sometimes don't [*Do you sometimes not*] admit to others that you had a good time. Tell me about it. (Does this happen fairly often?)						
46.	You've said that you have [*Have you*] *not* accomplished many of the personal goals that you have set for yourself. Tell me about them. (Why has that been? Was it that you lacked the ability or you just couldn't get it done?)	(6) fails to accomplish tasks crucial to his or her personal objectives despite demonstrated ability to do so (e.g., helps fellow students write papers, but is unable to write his or her own) 3 = many important goals not accomplished despite inherent ability	?	1	2	3	41
47	You've said that you are [*Are you*] not interested in, or even bored with, people who are nice to you. Tell me about that	(7) is bored with or uninterested in people who consistently treat him or her well, e.g., is unattracted to caring sexual partners 3 = several examples or one example and acknowledges trait	?	1	2	3	42

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

48. You've said that [*Do*] you almost always do what is good for other people rather than what is good for you.

    Give me some examples of that.

49. You've said that [*Do*] you do things for other people even when they don't want you to or try to discourage you.

    Give me some examples of that.

(8) engages in excessive self-sacrifice that is unsolicited and discouraged by the intended recipients of the sacrifice

? 1 2 3 45

3 = several examples of unsolicited and discouraged self-sacrifice or one example and acknowledges trait

AT LEAST FIVE SXS ARE CODED "3," I.E., DID NOT OCCUR ONLY WHEN DEPRESSED OR IN RESPONSE TO, OR IN ORDER TO AVOID, ABUSE

1 3 44

Self-Defeating PD

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

SCID-II (Version 1.0)

PARANOID PERSONALITY DISORDER

	PARANOID PERSONALITY DISORDER CRITERIA	
	A pervasive and unwarranted tendency, beginning by early adulthood and present in a variety of contexts, to interpret the actions of people as deliberately demeaning or threatening, as indicated by at least 4 of the following:	
50. You've said that [*Do*] you often have to keep an eye out to stop people from using you or hurting you. Tell me about that.	(1) expects, without sufficient basis, to be exploited or harmed by others 3 = several examples of unreasonable suspiciousness or one example and acknowledges trait	? 1 2 3
51. You've said that you're [*Are you*] sometimes not sure whether you can trust your friends or the people you work with. Describe situations where you've gotten that feeling. (Do you feel this way often?)	(2) questions, without justification, the loyalty or trust-worthiness of friends or associates 3 = several examples, clearly without justification, or one example and acknowledges trait	? 1 2 3
52. You've said that [*Do*] you often pick up hidden meanings in what people say or do. Give me some examples.	(3) reads hidden demeaning or threatening meanings into benign remarks or events, e.g., suspects that neighbor put trash out early to annoy him 3 = several examples or one example and acknowledges trait	? 1 2 3
53. You've said that you're [*Are you*] the kind of person who holds grudges or takes a long time to forgive people who have insulted or slighted you. Tell me about that.	(4) bears grudges or is unforgiving of insults or slights 3 = several examples of persistent resentment that is out of proportion to the harm done or one example and acknowledges trait	? 1 2 3
54. You've said that [*Do*] you find that it is best not to let other people know too much about you. Why is that?	(5) is reluctant to confide in others because of unwarranted fear that the information will be used against him or her 3 = acknowledges that reluctance to confide in others is due to mistrust (not merely fear of rejection)	? 1 2 3

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

55. You've said that [*Do*] you often get angry because someone has slighted you or insulted you in some way.

    Give me some examples.

56. You've said that you have [*Have you*] suspected that your spouse or partner has been unfaithful.

    Tell me about that.

    (What clues did you have? What did you do about it? Were you right?)

(6) is easily slighted and quick to react with anger or to counterattack 3 = several examples or one example and acknowledges trait	?	1	2	3	50
(7) questions, without justification, fidelity of spouse or sexual partner 3 = with several partners or on many occasions with the same partner	?	1	2	3	51
AT LEAST FOUR SXS ARE CODED "3"		1		3 Paranoid PD	52

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

SCHIZOTYPAL PERSONALITY DISORDER

SCHIZOTYPAL PERSONALITY DISORDER CRITERIA

A pervasive pattern of deficits in interpersonal relatedness, and peculiarities of ideation, appearance and behavior, beginning by early adulthood and present in a variety of contexts, as indicated by at least 5 of the following:

57. You've said that when you see people talking, you [*When you see people talking, do you*] often wonder if they are talking about you.

    Tell me more about this.

(1) ideas of reference (do not include delusions of reference) ? 1 2 3

3 = several examples

58. You've said that you've [*Have you*] often felt that the way things were arranged had a special significance for you.

    Tell me more about this.

59. You've said that [*Do*] you often feel nervous in a group of more than two or three people you don't know.

    Are you much more nervous than most other people would be?

(2) excessive social anxiety, e.g., extreme discomfort in social situations involving unfamiliar people ? 1 2 3

3 = claims to be much more nervous than most people in social situations or gives examples of clearly excessive anxiety

60. You've said that you have [*Have you ever*] felt that you could make things happen just by making a wish or thinking about them.

    Tell me about that.

    (How did it affect you?)

61. You've said that you've [*Have you*] had experiences with the supernatural, astrology, seeing the future, UFO's, ESP, or a personal experience with a "sixth sense."

    Tell me about that.

    (How did it affect you?)

(3) odd beliefs or magical thinking, influencing behavior and inconsistent with subcultural norms, e.g., superstitiousness, belief in clairvoyance, telepathy, or "6th sense," "others can feel my feelings" (in children and adolescents, bizarre fantasies or preoccupations) ? 1 2 3

3 = several examples of such phenomena that influenced behavior

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

62. You've said that [*Do*] you often mistake objects or shadows for people, or noises for voices.

    Give me some examples.

    (Were you drinking or taking drugs at the time?)

63. You've said that you have [*Have you*] had the sense that some person or force is around you, even though you cannot see anyone.

    Tell me more about that.

64. You've said that you've [*Have you*] had the experience of looking at a person or yourself in the mirror and seeing the face change right before your eyes.

    Tell me more about that.

	(4) unusual perceptual experiences, e.g., illusions, sensing the presence of a force or person not actually present (e.g., "I felt as if my dead mother were in the room with me") 3 = several examples of unusual perceptual experiences not due to drugs or a physical disorder	?	1	2	3	56
OBSERVED DURING INTERVIEW	(5) odd, eccentric, or peculiar behavior or appearance, e.g., is unkempt, has unusual mannerisms, talks to self	?	1	2	3	57
SEE AVOIDANT # 2 (p. 1)	(6) no close friends or confidants (or only one) outside of first-degree relatives (Also in Schizoid and Avoidant)	?	1	2	3	58
OBSERVED DURING INTERVIEW	(7) odd speech (without loosening of associations or incoherence), e.g., speech that is impoverished, digressive, vague, or inappropriately abstract	?	1	2	3	59
OBSERVED DURING INTERVIEW	(8) inappropriate or constricted affect, e.g., silly, aloof, rarely makes reciprocal gestures or facial expressions, such as smiles or nods	?	1	2	3	60
ANY OF FIRST FIVE PARANOID ITEMS	(9) suspiciousness or paranoid ideation	?	1	2	3	61
	AT LEAST FIVE SXS ARE CODED "3"		1		3	62
					Schizotypal PD	

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

	SCHIZOID PERSONALITY DISORDER CRITERIA				
	A pervasive pattern of indifference to social relationships, and restricted range of emotional experience and expression, beginning by early adulthood and present in a variety of contexts, as indicated by at least 4 of the following:				
65. You've said that you don't really [*Do you NOT*] need close relationships with other people, like family or friends. Tell me more about that. (Do you enjoy close relationships or being part of a family? IF NO: Would you just as soon have no close relationships?)	(1) neither desires nor enjoys close relationships, including being part of a family 3 = acknowledges trait	?	1	2	3
66. You've said that you would [*Would you*] rather do things alone than with other people. (Is that true both at work and during your free time?)	(2) almost always chooses solitary activities 3 = almost always chooses solitary work and leisure activities	?	1	2	3
67. You've said that [*Do*] you never seem to have really strong feelings, like being very angry or very happy. (Is it only that you don't let your feelings show?)	(3) rarely, if ever, claims or appears to experience strong emotions, such as anger and joy 3 = acknowledges no strong emotions, not just restricted expression	?	1	2	3
68. You've said that you could [*Could you*] be content without being sexually involved with another person. Tell me more about it. (Have you always had little interest in having sex with someone?)	(4) indicates little if any desire to have sexual experiences with another person (taking into account age) 3 = acknowledges trait	?	1	2	3
69. You've said that you don't [*Do you NOT*] care much about what people think of you. What about when people praise you or criticize you?	(5) is indifferent to the praise and criticism of others (a positive response is relevant to Narcissistic # 1 p. 21 and Avoidant # 1 p. 1) 3 = claims indifference to praise or criticism	?	1	2	3

?= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

SCID-II (Version 1.0)

SEE AVOIDANT # 2 (p. 1)

(6) has no close friends or confidants (or only one) other than first-degree relatives (Also in Schizotypal and Avoidant) ? 1 2 3 68

OBSERVED DURING INTERVIEW

(7) displays constricted affect, e.g., is aloof, cold, rarely makes reciprocal gestures or facial expressions, such as smiles or nods ? 1 2 3 69

AT LEAST FOUR SXS ARE CODED "3" 1 3 70

Schizoid P.D.

22 duplicate b
1-2 3-14 15

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

HISTRIONIC PERSONALITY DISORDER

HISTRIONIC PERSONALITY DISORDER CRITERIA

A pervasive pattern of excessive emotionality and attention-seeking, beginning by early adulthood and present in a variety of contexts, as indicated by at least 4 of the following:

70. You've said that [*Do*] you often go out of your way to get people to praise you.

    Give me some examples.

    (Do you do this a lot more than most people?)

(1) constantly seeks or demands reassurance, approval, or praise

3 = acknowledges unusual seeking of praise

? 1 2 3 16

71. You've said that [*Do*] you flirt a lot.

    Has anyone complained about this? (ALSO CONSIDER INTERVIEW BEHAVIOR)

72. You've said that [*Do*] you often dress in a sexy way when you are going to work or doing errands.

    Tell me about it. (ALSO CONSIDER APPEARANCE DURING INTERVIEW)

(2) is inappropriately sexually seductive in appearance or behavior

3 = acknowledges complaints, describes inappropriate behavior, or observed to be inappropriately seductive

? 1 2 3 17

73. You've said that it bothers [*Does it bother*] you more than most people if you don't look attractive.

    How upset are you if someone sees you when you don't look your best?

    (How much time do you spend getting ready to go out?)

(3) is overly concerned with physical attractiveness

3 = acknowledges being very upset if doesn't look attractive, or spends excessive amount of time on appearance (not due to rituals)

? 1 2 3 18

74. You've said that you are [*Are you*] very open with your emotions, for example, hugging people when you greet them or crying easily.

    Have people told you that you are too emotional?

    Give me some examples.

(4) expresses emotion with inappropriate exaggeration, e.g., embraces casual acquaintances with excessive ardor, sobs uncontrollably on minor sentimental occasions, has temper tantrums

3 = several examples of inappropriate expression of emotion, not limited to anger

? 1 2 3 19

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

75. You've said that [*Do*] you like to be the center of attention. How do you feel when you're not?	(5) is uncomfortable in situations in which he or she is not the center of attention 3 = acknowledges significant discomfort when not center of attention	?	1	2	3	20
OBSERVED DURING INTERVIEW	(6) displays rapidly shifting and shallow expression of emotions 3 = observed during the interview to shift rapidly from one mood state to another so that the emotion does not seem genuine (or reported by informants)	?	1	2	3	21
76. You've said that you're [*Are you*] the kind of person who can't wait to get what you want if you really want it. Is it hard for you to work at something that will only pay off in the long run? Give me an example of this.	(7) is self-centered, actions being directed toward obtaining immediate satisfaction; has no tolerance for the frustration of delayed gratification 3 = acknowledges no tolerance for delayed gratification and at least one example	?	1	2	3	22
OBSERVED DURING INTERVIEW	(8) has a style of speech that is excessively impressionistic and lacking in detail, e.g., when asked to describe mother, can be no more specific than "She was a beautiful person"	?	1	2	3	23
	AT LEAST FOUR SXS ARE CODED "3"		1		3 Histrionic PD	24

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

	NARCISSISTIC PERSONALITY DISORDER CRITERIA					
	A pervasive pattern of grandiosity (in fantasy or behavior), lack of empathy, and hypersensitivity to the evaluation of others, beginning by early adulthood and present in a variety of contexts, as indicated by at least 5 of the following:					
77. You've said that when you're criticized [*When you're criticized, do*] you often feel very angry, ashamed, or put down, even hours or days later. Give me some examples of this.	(1) reacts to criticism with feelings of rage, shame, or humiliation (even if not expressed) 3 = acknowledges prolonged reactions to criticism and at least one example	?	1	2	3	25
78. You've said that you've [*Have you*] sometimes had to use other people to get what you wanted. Tell me some instances of that. (Does that happen often?)	(2) is interpersonally exploitative: takes advantage of others to achieve his or her own ends 3 = several examples in which another person is exploited	?	1	2	3	26
79. You've said that you [*Do you*] sometimes "sweet talk" people just to get what you want out of them. Tell me about some of those situations. (Does this happen often?)						
80. You've said that [*Do*] you feel you are a person with special talents or abilities. Tell me more about that.	(3) has a grandiose sense of self-importance, e.g., exaggerates achievements and talents, expects to be noticed as "special" without appropriate achievement	?	1	2	3	27
81. You've said that people have [*Have people*] told you that you have too high an opinion of yourself. Give me some examples of this.	3 = evidence of obvious grandiosity. e.g., "I'm as good as Van Cliburn" rather than "I am a very talented pianist"					
82. You've said that when you have a problem, [*When you have a problem, do*] you almost always insist on seeing the top person. Give me some examples. (Is that true even for a relatively minor problem?)	(4) believes that his or her problems are unique and can be understood only by other special people 3 = insists on seeing the very top person for even minor problems, e.g., the head manager, the very best doctor	?	1	2	3	28

?= inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

83. You've said that [*Do*] you often daydream about achieving great things or being famous. Tell me more about this. (Do you spend a lot of time thinking about these things?)	(5) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love 3 = frequent daydreaming taking the place of appropriate activity	?	1	2	3	29
84. You've said that [*Do*] you often daydream about having a "perfect" romance. Tell me more about this. (Do you spend a lot of time thinking about this?)						
85. You've said that [*Do*] you think that it's not necessary to follow certain rules or social conventions when they get in your way. Give me some examples. (Do you feel that your situation is special so that you require preferential treatment?)	(6) has a sense of entitlement: unreasonable expectation of especially favorable treatment, e.g., assumes that he or she does not have to wait in line when others must do so 3 = several examples	?	1	2	3	30
86. You've said that it is [*Is it*] very important to you that people pay attention to you or admire you in some way. Tell me more about this.	(7) requires constant attention and admiration, e.g., keeps fishing for compliments 3 = several examples of distress when not singled out or admired, or acknowledges trait	?	1	2	3	31
87. You've said that people have said [*Have people said*] that you are not sympathetic or understanding about their problems. Give me some examples. (When other people tell you about their problems, do you "tune them out"?)	(8) lack of empathy: inability to recognize and experience how others feel, e.g., annoyance and surprise when a friend who is seriously ill cancels a date 3 = several examples, or direct acknowledgment that lack of empathy is characteristic	?	1	2	3	32
88. You've said that you are [*Are you*] often envious of other people. What about these other people makes you envious? (Would you say you spend too much time thinking about these things?)	(9) is preoccupied with feelings of envy 3 = often envious	?	1	2	3	33
	AT LEAST FIVE SXS ARE CODED "3"		1		3	34

NARCISSISTIC PD

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

BORDERLINE PERSONALITY DISORDER

	BORDERLINE PERSONALITY DISORDER CRITERIA				
	A pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts, as indicated by at least 5 of the following:				
89. You've said that [*Do*] your relationships with people you really care about have lots of ups and downs. Tell me about them. (Were there times when you thought they were everything you wanted and then other times when you thought they were terrible? How many relationships were like this?)	(1) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation 3 = either one prolonged relationship or several briefer relationships in which the alternating pattern occurs at least twice	?	1	2	3
90. You've said that you've [*Have you*] often done things impulsively. What kinds of things? (How about . . . . . . buying things you really couldn't afford? . . . having sex with people you hardly knew, or "unsafe sex"? . . . drinking too much or taking drugs? . . . driving recklessly? . . . uncontrollable eating? . . . shoplifting? IF YES TO ANY OF ABOVE: Tell me about that. How often does it happen? What kinds of problems has it caused?)	(2) impulsivity in at least two areas that are potentially self-damaging, e.g., spending, sex, substance use, shoplifting, reckless driving, binge eating [DO NOT INCLUDE SUICIDAL OR SELF-MUTILATING BEHAVIOR COVERED IN (5).] 3 = several examples indicating a pattern of impulsive behavior (not necessarily limited to above examples)	?	1	2	3
91. You've said that you are [*Are you*] a "moody" person. Tell me about that. (How long do your "bad" moods last? How often do these mood changes happen?)	(3) affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days 3 = frequent shifts of mood	?	1	2	3

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

92. You've said that [*Do*] you often have temper outbursts or get so angry that you lose control.

Tell me about this.

(4) inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights

3 = several examples, or one example and acknowledges trait

? 1 2 3 38

93. You've said that [*Do*] you hit people or throw things when you get angry

Tell me about this.

(Does this happen often?)

94. You've said that [*Do*] even little things get you very angry.

When does this happen?

(Does this happen often?)

95. You've said that you have [*Have you*] tried to hurt or kill yourself or threatened to do so.

(Have you ever cut or scratched yourself or done things like that?)

(5) recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior

3 = two or more times (when not in a Major Depression)

? 1 2 3 39

96. You've said that you are [*Are you*] different with different people or in different situations so that you sometimes don't know who you really are

Give me some examples of this.

(Do you feel this way a lot?)

97. You've said that you're [*Are you*] often confused about your long-term goals or career plans.

Tell me more about that.

(6) marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values

[Note: Do not include normal adolescent uncertainty about these issues]

3 = often uncertain about identity and is not limited to a circumscribed period of time

? 1 2 3 40

98. You've said that [*Do*] you often change your mind about the types of friends or lovers you want.

Tell me more about that

(Do you ever feel confused about whether you're gay or straight?)

99. You've said that you're [*Are you*] often not sure about what your real values are.

Tell me more about that.

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

100. You've said that [*Do*] you often feel bored or empty inside.

Tell me more about this.

(7) chronic feelings of emptiness or boredom

3 = acknowledges often feeling empty or bored

? 1 2 3

101. You've said that you have [*Have you*] often become frantic when you thought that someone you really cared about was going to leave you.

What have you done?

(Do you plead with him/her or try to prevent him/her from leaving?)

(8) frantic efforts to avoid real or imagined abandonment [DO NOT INCLUDE SUICIDAL OR SELF-MUTILATING BEHAVIOR COVERED IN (5).]

3 = at least two examples

? 1 2 3

AT LEAST FIVE SXS ARE CODED "3" 1 3

Borderline P.D.

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

ANTISOCIAL PERSONALITY DISORDER

	ANTISOCIAL PERSONALITY DISORDER CRITERIA					
	A. Current age at least 18.	?	1		3	44
	B. Evidence of Conduct Disorder with onset before age 15, as indicated by a history of 3 or more of the following:					
102. You've said that you often skipped school before you were 15. [*Before you were 15, did you often skip school?*] How often?	(1) was often truant	?	1	2	3	45
103. You've said that you ran away from home and stayed out overnight before you were 15. [*Before you were 15, did you run away from home and stay out overnight?*] Was that more than once? (With whom were you living at the time?)	(2) ran away from home overnight at least twice while living in parental or parental surrogate home (or once without returning)	?	1	2	3	46
104. You've said that before you were 15 you would [*Before you were 15, did you*] start fights. How often?	(3) often initiated physical fights	?	1	2	3	47
105. You've said that before you were 15 you used a weapon in a fight. [*Before you were 15, did you use a weapon in a fight?*] How many times?	(4) used a weapon in more than one fight	?	1	2	3	48
106. You've said that before you were 15 you forced someone to have sex with you. [*Before you were 15, did you ever force someone to have sex with you?*] Tell me about it.	(5) forced someone into sexual activity with him or her	?	1	2	3	49
107. You've said that before you were 15 you had [*Before you were 15, did you ever*] hurt an animal on purpose. What's the worst thing you ever did?	(6) was physically cruel to animals	?	1	2	3	50

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

Antisocial Personality 2

108. You've said that before you were 15 you had [*Before you were 15, did you ever*] hurt another person on purpose (other than in a fight). What's the worst thing you ever did?	(7) was physically cruel to other people	?	1	2	3
109. You've said that before you were 15 you deliberately damaged [*Before you were 15, did you deliberately damage*] things that weren't yours. What did you do?	(8) deliberately destroyed others' property (other than firesetting)	?	1	2	3
110. You've said that before you were 15 you [*Before you were 15, did you*] set fires. Tell me about that.	(9) deliberately engaged in firesetting	?	1	2	3
111. You've said that before you were 15, you lied a lot. [*Before you were 15, did you lie a lot?*] What would you lie about?	(10) often lied (other than to avoid physical or sexual abuse)	?	1	2	3
112. You've said that before you were 15 you sometimes stole things. [*Before you were 15, did you ever steal things?*] Tell me about it. (Did you ever forge anyone's signature?)	(11) has stolen without confrontation of a victim on more than one occasion (including forgery)	?	1	2	3
113. You've said that before you were 15 you robbed someone or mugged someone. [*Before you were 15, did you ever rob or mug someone?*] Tell me about that.	(12) has stolen with confrontation of a victim (e.g., mugging, purse-snatching, extortion, armed robbery)	?	1	2	3
	AT LEAST THREE SXS ARE CODED "3"		1		3

NOTE: IF FEATURES OF MORE THAN ONE SPECIFIC PERSONALITY DISORDER ARE PRESENT THAT DO NOT MEET THE FULL CRITERIA FOR ANY ONE. CONSIDER A DIAGNOSIS OF PERSONALITY DISORDER NOS. PAGE 30. OTHERWISE, END OF SCID-II

Hx of Conduct Disorder

Continue

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

NOTE: THE REMAINING ITEMS DO NOT APPEAR ON THE PERSONALITY QUESTIONNAIRE.

Now I am going to ask you questions about yourself since you were 15.

C. A pattern of irresponsible and antisocial behavior since the age of 15, as indicated by at least 4 of the following:

(1) is unable to sustain consistent work behavior, as indicated by any of the following (including similar behavior in academic settings if the person is a student): ? 1 2 3 58

How much of the time in the last five years were you not working?

IF MORE THAN SIX MONTHS: Why?

(a) significant unemployment for six months or more in five years when expected to work and work was available

When you were working, were you often absent?

IF YES: Why?

(b) repeated absences from work, unexplained by illness in self or family

Did you ever walk off a job without having another one to go to?

IF YES: How many times did this happen?

(c) abandonment of several jobs without realistic plans for others

Have you done things that are against the law—even if you weren't caught—like stealing, selling drugs, fencing, pimping, prostituting, or committing a felony?

Have you ever been arrested?

(2) fails to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing antisocial acts that are grounds for arrest (whether arrested or not), e.g., destroying property, harassing others, stealing, pursuing an illegal occupation ? 1 2 3 59

(Since you were 15) have you been in any fights that came to swapping blows?

(How often?)

Have you ever hit or thrown things at your (SPOUSE/PARTNER)?

(How often?)

Have you ever hit a child, yours or someone else's, so hard that he or she had bruises or had to stay in bed or see a doctor?

(3) is irritable and aggressive, as indicated by repeated physical fights or assaults (not required by one's job or to defend someone or oneself), including spouse- or child-beating ? 1 2 3 60

inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

Have you ever owed people money and not paid them back? (How often?)

What about not paying child support, or not giving money to children who depended on you?

(4) repeatedly fails to honor financial obligations, as indicated by defaulting on debts or failing to provide child support or support for other dependents on a regular basis.

? 1 2 3 61

(5) fails to plan ahead, or is impulsive, as indicated by one or both of the following:

? 1 2 3 62

Other than being on a vacation, have you ever traveled around without knowing where you were going to stay or work?

(a) traveling from place to place without a prearranged job or clear goal for the period of travel, or clear idea about when the travel will terminate

Was there ever a time when you had no regular place to live?

(For how long?)

(b) lack of a fixed address for a month or more

Have you done a lot of lying since you were 15?

Have you ever used an alias or pretended you were someone else?

Have you often "conned" others to get what you wanted?

(6) has no regard for the truth, as indicated by repeated lying, use of aliases, "conning" others for personal profit or pleasure

? 1 2 3 63

Did you ever drive a car when you were drunk?

How many times have you gotten a ticket for speeding?

(7) is reckless regarding his or her own or others' personal safety, as indicated by driving while intoxicated, recurrent speeding

? 1 2 3 64

IF HAS BEEN A PARENT OR GUARDIAN:
Has anyone ever said that you weren't taking proper care of a child of yours (or a child you were responsible for) . . .

. . by not providing enough food or . . .

. . keeping the child clean enough or . . .

. . getting medical care when the child was sick or . . .

. . leaving the child with neighbors because you weren't able to take care of the child at your home or . .

(8) if a parent or guardian, lacks ability to function responsibly, as indicated by one or more of the following:

? 1 2 3 65

(a) malnutrition of child

(b) child's illness resulting from lack of minimal hygiene

(c) failure to obtain medical care for a seriously ill child

(d) child's dependence on neighbors or nonresident relatives for food or shelter

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

. . not arranging for anyone to take care of the child when you were away or . . .

. . running out of money to take care of the child because you spent the money on yourself?

Have any of these things ever happened?

What's the longest period of time you were sexually involved with one person without having sex with anyone else?

Do you feel it was OK for you to have (stolen, hit, hurt, defaced/OTHER ANTISOCIAL ACT)?

(e) failure to arrange for a caretaker for young child when parent is away from home

(f) repeated squandering, on personal items, of money required for household necessities

(9) has never sustained a totally monogamous relationship for more than one year	?	1	2	3	66
(10) lacks remorse (feels justified in having hurt, mistreated, or stolen from another)	?	1	2	3	67
AT LEAST FOUR SXS ARE CODED "3"		1		3	68

Antisocial PD

PERSONALITY DISORDER NOS CRITERIA

This is a residual category for disorders of personality functioning that are not classifiable as a specific Personality Disorder. An example is: features of more than one specific Personality Disorder that do not meet the full criteria for any one, yet cause significant impairment in social or occupational functioning, or subjective distress.		1		3	69

Personality Disorder NOS

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

APPENDIX 4.3. THE SWAP-200 PERSONALITY DIAGNOSTIC INTERVIEW, 200 SWAP ITEMS AND RATING INSTRUCTIONS

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General principles:

(1) This interview should be conducted as a clinical interview, with probing as appropriate based on the interviewer's clinical skill, empathy, and hypotheses that emerge in listening to the material. As in clinical interviewing, if the patient says something with an ambiguous meaning, or which could lead to important information, the interviewer should ask about it.

(2) If interview questions become redundant because the answers are clear from previous responses, do not ask them (e.g., do not ask about depression if subject has already told of a history of depression). Interviewers should feel free to make *minor* wording changes to fit their interviewing style.

(3) If ruling out thought disorder, or if patient displays peculiarities in thinking, ask direct questions about psychotic symptoms as in a standard clinical interview.

(4) The interview should take about three hours. If it is taking much longer with a subject, the interviewer should ask for fewer vignettes or less detail as the interview proceeds, once s/he has a good "feel" for the patient.

(5) The interviewer should take notes during the interview on comments the subject makes that s/he wants to go back and inquire about, as well as comments of relevance to coding the interview. If Q-sorting from this interview, *be sure to do so within 24 hours after the interview*, after reviewing your notes. Delaying beyond 24 hours adds considerable error, since memory for specific details fades, and failing to read over your notes likewise introduces error because subjects frequently volunteer important facts about themselves at the beginning of the interview that are forgotten by the end.

1. Tell me a little bit about yourself, like who you are, what you do, and what you're like as a person.

2. (If subject is a patient:) Could you tell me about what brought you to the clinic/for treatment? (use whatever language is appropriate). (Interviewer should inquire about both the current complaint and history of psychiatric illness. If this interview is being used for clinical purposes, the interviewer should also inquire here about family history of mental disorder.) (If subject is not a patient:) Are there things in your life that bother you, worry you, or are often on your mind? (if necessary, add, "Like with important people in your life, or at work.")

3. Can you tell me a little bit about your childhood—what was it like growing up? (Probe for specific milestones or significant experiences, including losses, major illnesses, family moves, parental discipline, and abuse. Be sure to get a general impression about both childhood and adolescence.) What was school like for you?

4. Now I'd like you to describe your relationship with your mother—what was it like as a child, and what is it like now? (Use person the individual considers her/his psychological mother)

a. I'd like you to describe a specific encounter with your mother, something that stands out. It can be an incident that's typical of your relationship, really meaningful, really good, really bad—whatever comes to mind. (Probe if subject leaves out any of the following: what led up to the event, what both people were thinking and feeling, and the outcome; if subject has trouble with the task, give these probes at the beginning and repeat as necessary).

b. (ask for one or two more events; probe any that do not answer all the above instructions)

5. (same instructions with father; use person the individual considers her/his psychological father)

6. Do you have brothers and sisters? Could you describe them and your relationships with them?

a. Now I'd like you to describe a specific encounter with one of your brothers and sisters.

b. (ask for one more; if more than one sibling, ask for an encounter with a different sibling than described in 'a')

7. Was there anyone else who was really important to you as a child or teenager? (if necessary: "It could be a family member, like your grandmother or aunt, or some other person who made a difference to you." (probe for one specific incident)

8. Now I'd like to know a bit about your friendships. What were they like when you were a kid? Do you tend to have a lot of friends, just a few, or none at all?

a. Who are your closest friends? Could you tell me about your relationship with one of them—what is it like?

b. (probe for two specific incidents, either with one friend or different friends if the subject prefers)

c. Are you involved in many groups or activities with other people, like clubs, churches, or athletic groups?

d. What do you do for fun?

9. Can you tell me about your romantic relationships—what have they been like? Do your relationships tend to be stormy or smooth? (Be sure to get history of adult relationships.)

a. Are you currently married or romantically involved with someone? Could you tell me about the relationship?

b. (ask for two to three specific encounters)

c. Are you satisfied with your sex life? Have you always felt that way, or has it been different at different times or with different people? (probe gently for enjoyment, conflicts, and specific dysfunctions) Are there things that make you uncomfortable sexually, or that you don't like to do, that your partners (husband, wife, etc.) have wanted to do? Is there anything about your sex life that you think is unusual--that if other people heard about it, they would think it was strange, funny, or different? Have your partners ever complained about your sexual relationship or been unhappy with it? (for cultural groups in which questions under "c" would be impossible, ask instead the following, and gently probe: "Are there aspects of your marriage/relationship that leave you unsatisfied? What are the most unsatisfying things about your relationship? What are the most satisfying things about your relationship?" The interviewer should be certain that if s/he chooses not to ask specifically about sex this is because of cultural constraints, not her/his own discomfort in asking the questions.)

10. Could you tell me a little bit about your work history? (Probe if necessary: Do you tend to stay with jobs for a long time or move around a lot. Do you sometimes get into conflicts with people at work--co-workers or bosses?) (Probe also if signs of obsessionality) (If a homemaker, try to get a sense of the adequacy of her work at home and the extent to which she feels fulfilled at what she is doing.)

a. Tell me about a recent place you work or have worked, and about the people who work or worked with you.

b. (ask for one or two specific encounters at this job or others)

c. Are you satisfied with your financial situation? What are you like with money? (probe current living conditions and attitude toward money if interviewer suspects miserliness or maintenance of lower standard of living than can afford)

11. Now I'd like you to ask about some difficult times you've had in your life.

a. Try, if you can, to think about the most difficult, stressful, or upsetting time you've had as an adult. Can you tell me what happened and how you responded? (same

probes) (If subject has already clearly described what is obviously his/her most difficult time, do not ask this question.)

b. Now I'd like you to tell me about a time when you felt treated badly, hurt, or rejected by someone important to you. (probe for one incident, unless subject has clearly described such incidents and frequently feels hurt or rejected, in which case, do not ask this question because it is redundant)

c. Now I'd like you to think back over the last six months, and tell me about the three most stressful experiences you've had--they can be arguments with people important to you, work problems, financial problems, anything you experienced as really stressful. (For each, probe precisely how the person responded to the experience, including conscious coping strategies, such as things s/he said to him/herself.)

d. How does you body hold up when you're under stress? Do you often get sick, or have headaches, stomach problems, backaches, etc.? How is your health in general? (probe hypochondriasis)

e. Have you ever hurt yourself, deliberately cut or burned yourself, tried to kill yourself, or thought seriously about suicide? (if so, probe frequency, intensity, and at least one specific incident)

f Do you drink alcohol or use drugs? Have drugs or alcohol ever been a problem for you? (if ambiguous, ask if anyone else has ever worried that the subject has a drug or alcohol problem)

g. Have you ever been in trouble with the law?

12. Do you have children? (if yes, ask about relationships with them; if no, ask the following: "Are there situations in your life where you take care of other people?")

a. (if subject has children, ask to describe two incidents with them; if subject has more than one child, elicit info on two different children; if subject has no children, elicit one vignette on any caretaking relationship in which the subject is the caretaker)

b. Are there situations in which other people take care of you? How do you feel about being taken care of--do you like it? does it bother you? Can you give me an example of a

time someone took care of you that stands out in your mind as typical, meaningful, or problematic?

13. (If patient has a therapist): Can you tell me about your relationship with your therapist? (ask for one or two vignettes)

14. You've just described a lot of encounters you've had with different people. Is your personality different when you're with different people? (probe, e.g., with mother, spouse, etc.) How do these aspects of you fit together?

a. Do you ever feel like the parts of you *don't* fit together, or that you don't know who you are?

b. Has your personality changed a lot since you were a child, or are you basically the same person you always were? (Probe if necessary: "Is there some core part of you that is the same?")

c. How do you usually feel about yourself? Do your feelings about yourself change a lot from moment to moment or from day to day?

d. Have you noticed any differences in the way you are with men and with women? Do you tend to feel more comfortable with one or the other? (probe for one typical vignette with each if subject reports difference in level of comfort)

e. What are your goals and values in life, the things that are most important or mean the most to you? (probe religious or spiritual beliefs that appear to reveal loose thinking) Does life ever feel meaningless to you? What do you hope to accomplish in your lifetime—what are your aspirations? What's your biggest fear about what or who you could become?

f. You've told me a lot about your childhood and the people you grew up with. How do you think your childhood has affected you? (If necessary, ask how it has affected "the kind of person you are or psychological problems you've had." Do not ask this question if subject has already answered it in the context of other questions.)

15. Now I'd like to finish up by asking you some questions about your thoughts and emotions. (Probe for examples as needed throughout this section, but do not ask redundant questions if the answers to several of these are already clear)

a. What is your normal mood? Are you a moody person?

b. Do you tend to feel things really intensely? (probe for intensity of both pleasant and unpleasant emotions)

c. Do you often feel sad? Do you often feel ashamed or embarrassed? guilty? disgusted? angry? nervous? panicky? (probe irrational fears that interfere with life)

d. Do you often feel happy? Do you ever get so happy or feel so on top of the world that it's unrealistic--like you believe you can do anything?

e. Do feelings ever overwhelm you or feel so intense that you can't stand it? Are there times when you try to shut off your feelings entirely, or when you just feel numb?

f. What do you do when your feelings get really strong? What do you do when you're extremely angry? anxious?

g. Are you a superstitious person? Do you believe in ESP, or believe that people can read other people's minds? Do you ever have strange thoughts or feelings that come into your head, like sensing that another person is in the room, feeling like you're outside your body, or suddenly seeing images or hearing voices?

h. (For patients: "You've told me about [fill in the problems with which the patient has presented]. Do you have any other problems, or parts of your personality that you wish you could change?"

I've asked you a lot of questions. How has this been? Is there anything we haven't covered that's really important in understanding you as a person? Is there anything else you'd like to add, or anything you'd like to ask?

Shedler-Westen Assessment Procedure-200 (SWAP-200) Items

item #	*item text*
1	Tends to blame self or feel responsible for bad things that happen.
2	Is able to use his/her talents, abilities, and energy effectively and productively.
3	Takes advantage of others; is out for number one; has minimal investment in moral values.
4	Has an exaggerated sense of self-importance.
5	Tends to be emotionally intrusive; tends not to respect others' needs for autonomy, privacy, etc.
6	Is troubled by recurrent obsessional thoughts that s/he experiences as senseless and intrusive.
7	Appears conflicted about his/her racial or ethnic identity (e.g., undervalues and rejects, or overvalues and is preoccupied with, own cultural heritage).
8	Tends to get into power struggles.
9	Tends to think others are envious of him/her.
10	Feels some important other has a special, almost magical ability to understand his/her innermost thoughts and feelings (e.g., may imagine rapport is so perfect that ordinary efforts at communication are superfluous).
11	Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.
12	Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.
13	Tends to use his/her psychological or medical problems to avoid work or responsibility (whether consciously or unconsciously) .
14	Tends to blame others for own failures or shortcomings; tends to believe his/her problems are caused by external factors.
15	Lacks a stable image of who s/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing).
16	Tends to be angry or hostile (whether consciously or unconsciously).
17	Tends to be ingratiating or submissive (e.g., may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval).
18	When romantically or sexually attracted, tends to lose interest if other person reciprocates.
19	Enjoys challenges; takes pleasure in accomplishing things.
20	Tends to be deceitful; tends to lie or mislead.
21	Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging, competitive, etc.).
22	Tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.).

23	Tends to become involved in romantic or sexual "triangles" (e.g., is most interested in partners who are already attached, sought by someone else, etc.).
24	Tends to be unreliable and irresponsible (e.g., may fail to meet work obligations or honor financial commitments).
25	Has difficulty acknowledging or expressing anger.
26	Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused.
27	Has panic attacks lasting from a few minutes to a few hours, accompanied by strong physiological responses (e.g., racing heart, shortness of breath, feelings of choking, nausea, dizziness, etc.).
28	Tends to be preoccupied with concerns about dirt, cleanliness, contamination, etc. (e.g., drinking from another person's glass, sitting on public toilet seats, etc.).
29	Has difficulty making sense of other people's behavior; often misunderstands, misinterprets, or is confused by others' actions and reactions.
30	Tends feel listless, fatigued, or lacking in energy.
31	Tends to show reckless disregard for the rights, property, or safety of others.
32	Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.
33	Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.
34	Tends to be overly sexually seductive or provocative, whether consciously or unconsciously (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to "lead people on," etc.).
35	Tends to be anxious.
36	Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.
37	Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.).
38	Tends to feel s/he is not his/her true self with others; tends to feel false or fraudulent.
39	Appears to gain pleasure or satisfaction by being sadistic or aggressive toward others (whether consciously or unconsciously).
40	Tends to engage in unlawful or criminal behavior.
41	Appears unable to describe important others in a way that conveys a sense of who they as people; descriptions of others come across as two-dimensional and lacking in richness.
42	Tends to feel envious.
43	Tends to seek power or influence over others (whether in beneficial or destructive ways).
44	Perception of reality can become *grossly* impaired under stress (e.g., may become delusional).
45	Tends to idealize certain others in unrealistic ways; sees them as "all good," to the exclusion of commonplace human defects.
46	Tends to be suggestible or easily influenced.

47	Is unsure whether s/he is heterosexual, homosexual, or bisexual.
48	Seeks to be the center of attention.
49	Has fantasies of unlimited success, power, beauty, talent, brilliance, etc.
50	Tends to feel life has no meaning.
51	Tends to elicit liking in others.
52	Has little empathy; seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own.
53	Seems to treat others primarily as an audience to witness own importance, brilliance, beauty, etc.
54	Tends to feel s/he is inadequate, inferior, or a failure.
55	Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others.
56	Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.
57	Tends to feel guilty.
58	Has little or no interest in having sexual experiences with another person.
59	Is empathic; is sensitive and responsive to other peoples' needs and feelings.
60	Tends to be shy or reserved in social situations.
61	Tends to disparage qualities traditionally associated with own sex while embracing qualities traditionally associated with opposite sex (e.g., a woman who devalues nurturance and emotional sensitivity while valuing achievement and independence).
62	Tends to be preoccupied with food, diet, or eating.
63	Is able to assert him/herself effectively and appropriately when necessary.
64	Mood tends to cycle over intervals of weeks or months between excited and depressed states (high placement implies bipolar mood disorder).
65	Seeks to dominate an important other (e.g., spouse, lover, family member) through violence or intimidation.
66	Is excessively devoted to work and productivity, to the detriment of leisure and relationships.
67	Tends to be stingy and withholding (whether of money, ideas, emotions, etc.)
68	Appreciates and responds to humor.
69	Has difficulty discarding things even when they are worn-out or worthless; tends to hoard, collect, or hold onto things.
70	Has uncontrolled eating binges followed by "purges" (e.g., makes self vomit, abuses laxatives, fasts, etc.); has bulimic episodes.
71	Tends to seek thrills, novelty, adventure, etc.
72	Perceptions seem glib, global, and impressionistic; has difficulty focusing on specific details.
73	Tends to "catastrophize"; is prone to see problems as disastrous, unsolvable, etc.
74	Expresses emotion in exaggerated and theatrical ways.
75	Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance.

76	Manages to elicit in others feelings similar to those he or she is experiencing (e.g., when angry, acts in such a way as to provoke anger in others; when anxious, acts in such a way as to induce anxiety in others).
77	Tends to be overly needy or dependent; requires excessive reassurance or approval.
78	Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).
79	Tends to see certain others as "all bad," and loses the capacity to perceive any positive qualities the person may have.
80	Tends to be sexually possessive or jealous; tends to be preoccupied with concerns about real or imagined infidelity.
81	Repeatedly re-experiences or re-lives a past traumatic event (e.g., has intrusive memories or recurring dreams of the event; is startled or terrified by present events that resemble or symbolize the past event).
82	Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it.
83	Beliefs and expectations seem cliché or stereotypical, as if taken from story-books or movies.
84	Tends to be competitive with others (whether consciously or unconsciously).
85	Has conscious homosexual interests (moderate placement implies bisexuality; high placement implies exclusive homosexuality).
86	Tends to feel ashamed or embarrassed.
87	Is quick to assume that others wish to harm or take advantage of him/her; tends to perceive malevolent intentions in others' words and actions.
88	Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.
89	Appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences.
90	Tends to feel empty or bored.
91	Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects.
92	Is articulate; can express self well in words.
93	Seems to know less about the ways of the world than might be expected, given his/her intelligence, background, etc.; appears naive or innocent.
94	Has an active and satisfying sex life.
95	Appears comfortable and at ease in social situations.
96	Tends to elicit dislike or animosity in others.
97	Tends to use his/her physical attractiveness to an excessive degree to gain attention or notice.
98	Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.
99	Appears to associate sexual activity with danger (e.g., injury, punishment, contamination, etc.), whether consciously or unconsciously.
100	Tends to think in abstract and intellectualized terms, even in matters of personal import.
101	Generally finds contentment and happiness in life's activities.

102	Has a specific phobia (e.g., of snakes, spiders, dogs, airplanes, elevators, etc.).
103	Tends to react to criticism with feelings of rage or humiliation.
104	Appears to have little need for human company or contact; is genuinely indifferent to the presence of others.
105	Tends to avoid confiding in others for fear of betrayal; expects things s/he says or does will be used against him/her.
106	Tends to express affect appropriate in quality and intensity to the situation at hand.
107	Tends to express qualities or mannerisms traditionally associated with own sex to an exaggerated degree (i.e., a hyper feminine woman or hyper masculine, "macho" man).
108	Tends to restrict food intake to the point of being underweight and malnourished.
109	Tends to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.).
110	Tends to become attached to, or romantically interested in, people who are emotionally unavailable.
111	Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.
112	Tends to be unconcerned with the consequences of his/her actions; appears to feel immune or invulnerable.
113	Appears to experience no remorse for harm or injury caused to others.
114	Tends to be critical of others.
115	Tends to break things or become physically assaultive when angry.
116	Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.
117	Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.
118	Tends to see sexual experiences as somehow revolting or disgusting.
119	Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.
120	Has moral and ethical standards and strives to live up to them.
121	Is creative; is able to see things or approach problems in novel ways.
122	Living arrangements tend to be chaotic or unstable (e.g., living arrangements are temporary, transitional, or ill-defined; may have no telephone or permanent address).
123	Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.
124	Tends to avoid social situations because of fear of embarrassment or humiliation.
125	Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or "off").
126	Appears to have a limited or constricted range of emotions.
127	Tends to feel misunderstood, mistreated, or victimized.
128	Fantasizes about finding ideal, perfect love.

129	Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.).
130	Reasoning processes or perceptual experiences seem odd and idiosyncratic (e.g., may make seemingly arbitrary inferences; may see hidden messages or special meanings in ordinary events).
131	Has difficulty allowing self to experience strong pleasurable emotions (e.g., excitement, joy, pride).
132	Tends to have numerous sexual involvements; is promiscuous.
133	Tends to be arrogant, haughty, or dismissive.
134	Tends to act impulsively, without regard for consequences.
135	Has unfounded fears of contracting medical illness; tends to interpret normal aches and pains as symptomatic of illness; is hypochondriacal.
136	Tends to be superstitious or believe in magical or supernatural phenomena (e.g., astrology, tarot, crystals, ESP, "auras," etc.).
137	Shows evidence of unconscious homosexual wishes or interests (e.g., may be excessively homophobic, or may show signs of unacknowledged attraction to a person of the same sex).
138	Tends to enter altered, dissociated state of consciousness when distressed (e.g., the self or the world feels strange, unfamiliar, or unreal).
139	Tends to hold grudges; may dwell on insults or slights for long periods.
140	Has a sexual perversion or fetish; rigidly-scripted or highly idiosyncratic conditions must be met before s/he can experience sexual gratification.
141	Is extremely identified with a social or political "cause," to a degree that seems excessive or fanatical.
142	Tends to make repeated suicidal threats or gestures, either as a "cry for help" or as an effort to manipulate others.
143	Tends to believe s/he can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise "special."
144	Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential.
145	Speech tends to be circumstantial, vague, rambling, digressive, etc.
146	Tends to elicit boredom in others (e.g., may talk incessantly, without feeling, or about inconsequential matters).
147	Tends to abuse alcohol.
148	Has little psychological insight into own motives, behavior, etc.; is unable to consider alternate interpretations of his/her experiences.
149	Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.
150	Tends to identify with admired others to an exaggerated degree; tends to become an admirer or "disciple" (e.g., may take on the other's attitudes, beliefs, mannerisms, etc.).
151	Appears to experience the past as a series of disjointed or disconnected events; has difficulty giving a coherent account of his/her life story.
152	Tends to repress or "forget" distressing events, or distort memories of distressing events beyond recognition.
153	Interpersonal relationships tend to be unstable, chaotic, and rapidly changing.

154	Tends to elicit extreme reactions or stir up strong feelings in others.
155	Tends to describe experiences in generalities; is unwilling or unable to offer specific details.
156	Has a disturbed or distorted body-image; sees self as unattractive, grotesque, disgusting, etc.
157	Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.
158	Appears afraid of commitment to a long-term love relationship.

159	Tends to deny or disavow own needs for caring, comfort, closeness, etc., or to consider such needs unacceptable.
160	Lacks close friendships and relationships.
161	Tends to abuse illicit drugs.
162	Expresses contradictory feelings or beliefs without being disturbed by the inconsistency; has little need to reconcile or resolve contradictory ideas.
163	Appears to want to "punish" self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification.
164	Tends to be self-righteous or moralistic.
165	Tends to distort unacceptable wishes or feelings by transforming them into their opposite (may express excessive concern or affection while showing signs of unacknowledged hostility; disgust about sexual matters while showing signs of unacknowledged interest or excitement; etc.).
166	Tends to oscillate between undercontrol and overcontrol of needs and impulses (i.e., needs and wishes are expressed impulsively and with little regard for consequences, or else disavowed and permitted virtually no expression).
167	Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).
168	Struggles with genuine wishes to kill him/herself.
169	Fears becoming like a parent (or parent figure) about whom s/he has strong negative feelings; may go to lengths to avoid or reject attitudes or behaviors associated with that person.
170	Tends to be oppositional, contrary, or quick to disagree.
171	Appears to fear being alone; may go to great lengths to avoid being alone.
172	Experiences a specific sexual dysfunction during sexual intercourse or attempts at intercourse (e.g., inhibited orgasm or vaginismus in females, impotence or premature ejaculation in males).
173	Tends to become absorbed in details, often to the point that s/he misses what is significant in the situation.
174	Expects self to be "perfect" (e.g., in appearance, achievements, performance, etc.).
175	Tends to be conscientious and responsible.

176	Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe the self and another person, believe the two share identical thoughts and feelings, treat the person as an "extension" of him/herself, etc.).
177	Repeatedly convinces others of his/her commitment to change but then reverts to previous maladaptive behavior; tends to convince others that "this time is really different."
178	Is preoccupied with the feeling that someone or something has been irretrievably lost (e.g., love, youth, the chance for happiness, etc.).
179	Tends to be energetic and outgoing.
180	Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices.
181	Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.
182	Tends to be controlling.
183	Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.
184	Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying non-verbal messages.
185	Tends to express intense and inappropriate anger, out of proportion to the situation at hand.
186	Has difficulty directing both tender feelings and sexual feelings toward the same person (e.g., sees people as respectable and virtuous, or sexy and exciting, but not both).
187	Tends to feel guilty or ashamed about his/her sexual interests or activities (whether consciously or unconsciously).
188	Work life tends to be chaotic or unstable (e.g., working arrangements seem always temporary, transitional, or ill-defined).
189	Tends to feel unhappy, depressed, or despondent.
190	Appears to feel privileged and entitled; expects preferential treatment.
191	Emotions tend to change rapidly and unpredictably.
192	Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.
193	Lacks social skills; tends to be socially awkward or inappropriate.
194	Tries to manipulate others' emotions to get what s/he wants.
195	Tends to be preoccupied with death and dying.
196	Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.
197	Tends to seek out or create interpersonal relationships in which s/he is in the role of caring for, rescuing, or protecting the other.
198	Is not verbally articulate; has limited ability to express self in words.
199	Tends to be passive and unassertive.
200	Is able to form close and lasting friendships characterized by mutual support and sharing of experiences.

SWAP-200
Instructions for Use

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Please do not begin work until you have read all instructions *carefully*.

Overview

The SWAP-200 is a set of 200 statements that will allow you to describe a patient's psychological functioning. Each statement is printed on a separate card, approximately the size of a business card. Each statement will apply to a given patient more, less, or not at all.

Your task is to arrange the statements into eight categories or piles, according to the degree to which the statements apply to the patient you are describing. The first pile (pile 0) will contain statements that are not true of your patient, are irrelevant, or concern matters about which you have no information. This will be the largest pile by far. The next pile (pile 1) will contain statements that may apply to your patient just a little bit; the next (pile 2) will contain statements that apply a little bit more, and so on. The last pile (pile 7) will contain statements that describe your patient especially well—that seem to capture what is most central about his or her personality.

You should place statements higher (i.e., closer to pile 7) depending either on the pervasiveness or the extremeness of the characteristic in question (or both). For example, you might give high placement to the statement "Tends to be overly needy and dependent" (item 77) either because the patient often appears needy, or because, on occasions when the patient is needy, the level of neediness seems extreme.

Each of the eight piles must contain a specific number of cards. When you have finished arranging the cards, you should have the following number of cards in each pile:

pile:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
number of cards:	**100**	**22**	**18**	**16**	**14**	**12**	**10**	**8**

To get the right number in each pile, you will have to make choices that may sometimes seem arbitrary. For example, you may have to choose whether it is more true that your patient "Fantasizes about finding ideal, perfect love" (item 128) or more true that s/he "Tends to act impulsively, without regard for consequences" (item 134). Such choices are difficult, but are a necessary part of the procedure.

How to work

You will need a large desk or table.

1. Begin by sorting the cards into three or four piles. Read each card in turn. If you think a statement does not describe the patient at all, put it in the left-hand pile. If you think it describes the patient extremely well, put it in the right-hand pile. Use the middle piles for statements that fall somewhere in between.

2. Now examine the cards in the right right-most pile and pick the eight statements that best describe your patient. These statements will become **pile 7**. Then, pick the *next* 10 most descriptive statements, which will make up pile six (if you do not have enough cards, choose the most applicable statements from the next lower pile and move them up). Repeat the process for each pile, working from right to left, until you have the correct number of cards in each pile. (Obviously, when you get the correct number of cards in piles 1 through 7, it will not be necessary to count the cards in pile 0.)

How to interpret the SWAP-200 statements

The intent of many of the SWAP-200 statements is to describe subtle psychological processes. Evaluating these statements requires clinical inferences that go beyond the face value of the patient's words and actions. Trust your clinical judgment--but do not place items in the most descriptive piles (5,6, or 7) unless you are quite certain that they are true of the patient.

Do not be concerned if you give high placement to statements that seem mutually contradictory. People often have conflicting or contradictory attributes, and the SWAP-200 is designed to reflect this.

We are interested in obtaining a description that reflects the patient's stable or enduring qualities, not simply momentary states. Please describe the patient as s/he has been *during the past six months*. For example, if you are describing a patient who is a recovered alcoholic, who has not had a drink in several years, the statement "tends to abuse alcohol" (item 147) should be placed low.

Data recording

Take the cards in "pile 0" (those that are least descriptive of your patient), rubber band them, and place them in the pre-addressed return envelope provided. For the remaining piles, we have provided small envelopes numbered "1" through "7." Place the cards in pile 1 (those that are not very true of your patient) in the envelope numbered 1, place the cards in pile 2 in the envelope numbered "2," and so on. *Please, please, be careful not to reverse the order!* Seal all the small envelopes (so the cards will not fall out of them in

the mail), then place them in the pre-addressed return envelope along with the rubber-banded cards from pile 0. Place all additional survey forms in the pre-addressed envelope as well, and mail it back to us.

Additional feedback

After you have completed the SWAP-200 procedure, please take a moment to respond to the questions below:

Were you able to express what you feel is most important about this patient? (check one)

____I was able to express most of the things I consider important about this patient.
____I was able to express some of the things I consider important about this patient.
____I was able to express relatively few of the things I consider important about this patient.
____I was not able to express the things I consider important.

Last but not least:

If you feel the SWAP-200 did not permit you to express something important, please use the back of this sheet to add additional descriptions. We will use your comments to refine future versions of the SWAP. Also, if you feel the wording of any statements was unclear or ambiguous, please note this on the back of this sheet. We welcome suggestions for revisions or rewrites.

Thank you for your time and effort. Your participation represents a major contribution to the success of the Harvard Collaborative Assessment Project.

APPENDIX 4.4. THE SF-36 HEALTH SURVEY QUESTIONNAIRE AND RATING SHEET

SF-36 HEALTH SURVEY

Subject _____

Interviewer _____

Date _____

THE MOS 36-ITEM SHORT-FORM HEALTH SURVEY (SF-36)

INSTRUCTIONS: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

(circle one)

Excellent 1

Very good 2

Good 3

Fair 4

Poor 5

2. Compared to one year ago, how would you rate your health in general now?

(circle one)

Much better now than one year ago 1

Somewhat better now than one year ago 2

About the same as one year ago 3

Somewhat worse now than one year ago 4

Much worse now than one year ago 5

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

ACTIVITIES	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
a. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing **several** flights of stairs	1	2	3
e. Climbing **one** flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking **more than a mile**	1	2	3
h. Walking **several blocks**	1	2	3
i. Walking **one block**	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(circle one number on each line)

	YES	NO
a. Cut down on the **amount of time** you spent on work or other activities	1	2
b. **Accomplished less** than you would like	1	2
c. Were limited in the **kind** of work or other activities	1	2
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(circle one number on each line)

	YES	NO
a. Cut down the **amount of time** you spent on work or other activities	1	2
b. **Accomplished less** than you would like	1	2
c. Didn't do work or other activities as **carefully** as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(circle one)

Not at all 1

Slightly 2

Moderately 3

Quite a bit 4

Extremely 5

7. How much bodily pain have you had during the past 4 weeks?

(circle one)

None 1

Very mild 2

Mild 3

Moderate 4

Severe 5

Very severe 6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one)

Not at all 1

A little bit 2

Moderately 3

Quite a bit 4

Extremely 5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks -

(circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of pep?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

All of the time 1

Most of the time 2

Some of the time 3

A little of the time 4

None of the time 5

11. How TRUE or FALSE is each of the following statements for you?

(circle one number on each line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

SF 36

SCORING

TABLE

Physical Functioning	3a	3b	3c	3d	3e	3f	3g	3h	3i	3j	Total	-10	÷20	x100	Total
Role Physical	4a	4b	4c	4d							Total	-4	÷4	x100	Total
Bodily Pain	7	8									Total	-2	÷10	x100	Total
General Health	1	11a	11b	11c	11d						Total	-5	÷20	x100	Total
Vitality	9a	9e	9g	9i							Total	-4	÷20	x100	Total
Social Functioning	6	10									Total	-2	÷8	x100	Total
Role-Emotional	5a	5b	5c								Total	-3	÷3	x100	Total
Mental Health	9b	9c	9d	9f	9h						Total	-5	÷25	x100	Total
Reported Health	2														Total

RATING SCHEDULE FOR APFA

F Nr: _____ d.o.b.: _____ baseline: _____ current: _____

date of interview: _____ interviewer: _____ rater: _____

I.D.:	Work L/Ty	Work L. Opp.	Work Ill. Rel.	Work Pos.Fea	Love L/Ty	Love L. Opp.	Love Ill. Rel.	Love Pos.Fea	Friends L/Ty	Friends L. Opp.	Friends Ill. Rel.	Friends Pos.Fea	N-S S C L/Ty	N-S S C L. Opp.	N-S S C Ill. Rel.	N-S S C Pos.Fea
Base-line (1)																
Current (2)																

I.D.:	Nego. L/Ty	Nego. L. Opp.	Nego. Ill. Rel.	Nego. Pos.Fea	Coping L/Ty	Coping L. Opp.	Coping Ill. Rel.	Coping Pos.Fea
Base-line (1)								
Current (2)								

Level\Types: 1= Remarkebly good functioning
2= Okay functioning, nothing remarkable
3= Pattern is okay but some concern
1,2 and 3 rated without Type
4= Clear evidence of significant difficulties with background of okay functioning
5= Correspond to a 6 but with some significant functioning
6= Picture dominated by discord, disagreement, disorganization, conflictual (note: hard rating for avoidant type)
4, 5 and 6 rated with Type

Type 1= no dysfunction
Type 2= discord, arguments, tension, aggression, violence
Type 3= avoidant, apathy, lack of involvement

Lack of Opportunity: 0= None
1= N-Institutional
2= Hospital
3= Prison
4= 1 and 2
5= 1 and 3
6= 2 and 3

Illness Related: 0= None
1= Drug\alcohol
2= Psychiatry
3= Physical., dubious origin
4= Physical, disability

Positive Features: 0= None
1= Probable
2= Definite

APPENDIX 4.6. THE TRANSITIONS AND PLANS INTERVIEW (TAPI) RATING INSTRUCTIONS AND RATING SHEET

A plan is a cognitive representation of intention. A course of action aimed towards a goal.

The aim is to rate up to 3 main plans in each domain. At least one of these in each domain should be a current plan this includes plans for the future which may be particularly important in maintaining hope and self esteem.

Status of plan: Note that here current plans should also include plans for the future.

Duration of Idea:This refers to when the subject first began to think about the idea for the plan. There need not be any evidence of planning for sometime.

Practical steps taken: Rate the highest number which fits the plan being rated . Definite steps should not include just preliminary contacts such as picking up forms etc. To rate as definite steps there needs to be some definite commitment to something or someone. That is , the step is likely to result in some consequences or action.

Acknowledgement of idea to others:Significant other here means any of the six key people in the persons life as rated in the interview. It could also be an employer, it needs to be someone who the subject has regular

contact with ,i.e. in the sense that there is likely to be some comeback regarding the acknowledgement of the idea to this person.

Success/Rewards: A rating of one should only be given if the success or reward is definite and has some lasting positive consequences for the subjects plan. For example ,having a job interview but not getting a job would not count unless there was a definite positve outcome of the interview for the subject.A positive experience needs to reinforce the subjects plan and reafirm the persons belief in the plan in someway, in order to rate here. For current or future plans only rate success if there is also optimism for the next step or satisfacton with the current situation.

Setbacks: A setback here is an event which substantially slowed down the progress of the plan or threatened failure of the plan. Major disappointments should be included ,i.e. where expectations were not met.

Plans devised by another person:Rate one here when the subject has been clearly under pressure to take a certain route or course of action by a significant other such as a parent,other family member , or teacher. Also rate one if the subject definitely had no ideas of their own and put up little resisitance to the pressure to follow a definite plan devised by the significant other. Do not rate one if a subjects plan began because of a one off suggestion from someone else more consistent pressure and influence must be exerted than this.

Current Investment/Committment:This scale aims to assess

investment/committment to the plan being rated and not time spent ,committment may be high but little time actually spent in some cases. When making the rating ,consider only those other options and plans within the domain not across domains,e.g.consider other plans in work when assessing a plan related to work or career ,but do not take into account committment to family or independent living. It would therefore be possible for someone to get 3 on all four domains although this would be unusual.

3 Maximumm possible investment/committment

2 High investment/commitment but not maximum

1 Moderate to low invesment /commitment

0 Very little or none.

Current satisfaction:Rate here current satisfaction with the plan a rating of 8 i.e. not applicable, if the plan is not current , this also applies to the previous rating of current investment/commitment

3 little or not discrepancy between actual and ideal currently.

2 considerable satisfaction

1 some satisfaction

0 very little or no satisfaction, major discrepancy between actual and ideal.

PLANNING: Re. Transition Events

This refers to evidence of concious thought regarding a descion to undertake the transition.

1 Definitely planned: To rate 1 the transition must be part of a plan the subject has described or has cleraly indicated in some other way to the interviewer.

2 Possibly Planned: To rate here planning of some form must be evident or very likely given what the subject has said but the transition is not occurring in accordance with an articulated plan in the way it would need to to rate 1

3 Passive planning: Rate here if the planning involved to make the transition was clearly someone elses plan for the subject. This would apply if the subject either could not think of anything else they wanted to do or felt they had no choice in the matter. This lack of choice could have resulted from there being no apparent alternative available or where the subjects choice was perceived by them to be severely restricted for other reasons, such as restrictive social circumstances beyond their control at the time.

4 Planning unclear: Rate here when the importance or type of planning is impossible to determine but their is no definite evidence that the transition was unplanned.

5 Definitely not planned: Rate here if the subject clearly indicates that the transition was not planned in any way as defined in the measures of plans.To rate as planned there must be some indication that the subject had intended to under take the course of action taken several moths prior to actually doing so. In some cases the need for several months prior thought need not apply,for example if a transition occurred quite quickly but was generally in accordance with the subjects overrall plan.
If the transition event is the direct consequence of another unplanned occurrence such as a marriage following an unplanned pregnancy and the transition of the marriage was not planned at all prior to the occurance of the pregnancy both transitons in this case would rate 5.

NB. When rating planning here it is important to consider the perception of choice. For a transition to rate as definitely planned there needs to have been at least some perceived choice.

READINESS: This refers to whether the transition was perceived as coming at the right time by the subject at the time, the subjects report is obviously a retrospective reconstruction of whether they felt ready for the transition. It is important to try to rate the perception at the time rather than what the subject thinks now about what they did.

1 Completely Ready: To rate 1 the subject must report feeling ready in the sense that they were keen to embrace the challenge of the transition.

2 Partly Ready: Rate here when feelings are mixed regarding the timing of the transition or where there is no evidence of a clear desire to take the step involved in the transition.

3 Unready: Rate here when the subject clearly describes feeling unready for the challenge involved in the transition or when the transition occurred at a bad time ,either too early or less commonly too late.

DESIRABILITY: Here the aim is to assess whether the subject perceived the transition as desirable for them ,that is a positive step.

1 Highly desirable: This rating should be used for those transitions which are unequivocally positive with regard to the subjects plans. i.e the best the could have achieved or what they hoped for.

2 Partially desirable: Rate here when there are predominantly positive aspect to the transition but where there are also some definite negative aspects as well.

3 Undesirable: Rate here when the transition is predominantly negative in its effect on the subject and is peceived by the subject to have a predominantly undesirable impact.

NB. The use of the term positive here is intended to mean in accordance with the subjects expectations for the timing of the transition and for the type of progress they want to make with regard to their transition to adulthood.

DRAFT 12/01/89

RATING NOTES FOR THE CLASSIFICATION OF TRANSITIONS

WORK

01 First Job

The first job cannot be counted till the subject has left continuous full-time education. Therefore do not include weekend, evening or seasonal jobs while at school or college or the holidays in between.

The first job since leaving education should always be taken even if the subject intends to return to study at a later date. The exception to this is if there is a definite plan to take up a specific kind of work which is more prestigious/desirable within 3-6 months. This is to eliminate stop-gap or seasonal jobs. For example, if a subject knows they have a job as a secretary starting in a few months time and they fill the time till then with clerical temping, the first job would be that of the secretary. If the subject has no definite plans, the first job after leaving education should be counted even if this is temporary or seasonal work.

The same principals apply to part-time work though the total hours worked per week must be at least 18 to be rated as a first job.

On the job training such as that required for apprentices and student nurses are to be treated as jobs rather than full-time education as the subject would be receiving a wage.

02 Best Job

This is to show the subject in the best light where it is not easy to do so by other codings. This means a change of job for the better and cannot take place within the same line of work. In such cases it would be regarded as a promotion.

This improvement must be in accordance with what the subject wants for themselves so the step-up might not necessarily be in terms of money or prestige. Therefore this code should only be included if the previous job(s) showed the subject had poor ratings on planning, desirabilty and readiness and now they are high.

If a subject had a set back in their work plans and then they started a clearly better job this would only be rated if this improvement resulted in the best job in their work history to date.

Responsibilty for others takes precedence over best job. Do not rate both for the same job move.

04 Promotion (Most responsible/most recent)

A promotion must involve an increase in status within a type of work denoted by a change in job title. Other indcators may be an increase in pay, more responsibility or more autonomy.

This need not take place within the same organisation as long as the subject has moved along a progression of increasing status within a type of work which has a clear promotional structure. For example, if a teacher moves up a grade on transferring to a different educational authority this would come as a promotion.

Problems may arise if, for example, somebody moves from a foreman in one firm to an assistant manager in another especially if they are not of comparable size or hierarchical set up. The only instances where such situations are likely to be rated is if the companies have a common source, for example, a move to or from a parent company. If in doubt do not rate.

If a promotion involves responsibilty for others then these ratings always take precedence over promotion, i.e., do not rate both for the same job move.

05 Responsibility for others at work (First)

06 Responsibility for others at work
(Most responsible/most recent)

In order to rate here a subject must have direct responsibility for the work and welfare of somebody and they are answerable for their conduct. Having people lower on a job hierarchy who the subject may have to instruct or keep an eye on is not sufficient.

Responsibility for others at work takes precedence over promotion and better job i.e. do not rate these if they occur at the same time as responsibilty for others.

07 Major change in work

This rating is to be used if the subject has taken up a completely different type of work where it is not really posssible to directly compare with previous employment. It is not related to job status or the desirability of the change. For example, you would not include if a lorry driver became a taxi driver but you would if they took up market gardening.

This transition is not aimed at changes between full and part-time work. This code should only be used if there has been a loss of investment in one line of work, i.e., do not include if somebody has had a lot of different jobs in a number of years and no change is any more significant than any other.

08 Starting own business (first)

This is marked by the point at which the subject launches themself into a scheme which will become their sole or main income. This would include those people who were previously unemployed and those aided by a grant.

There needs to be committment and some investment made by the subject and is not meant to cover businesses that are a supplement to their main employment.

It is also for those subjects who become self-employed. Exceptions to this would be those people who did jobs where self employment may be a common feature and there is little increase in responsibility or risk involved. Examples of this are often found in trades like building or hair dressing. For example, if an employed hairdresser left to set up their own business they have undergone this transition. If however they left to work in another salon and the only difference from the previous work is they are responsible for their own national insurance stamps then they have not.

09 Given up work to have a child (First)

10 Given up work to have a child (Most recent)

This transition usually applies to women and is used to illustrate the point at which a subject looses their status of worker to that exlusively of child carer. This does not include those women who take maternity leave and plan to go back to work within the period specified by the job. If while on maternity leave a decision is made not to return to work or take extended leave then this transition is counted from that point.

11 Becoming a working mother

Code for those women who have either returned to work after maternity leave or at a later date after having a child. What we are looking for is a committment to both the role of mother and the role of paid worker. This would include the need to work for financial reasons and consequently the subject feels unable to give up at a moments notice. However the minimum number of hours to classify here is about 18 per week so this code is not meant to include those women who do very part-time jobs such as a few hours cleaning, working behind the bar or casual work at home.

12 Left school

This code only applies to school and not college and therefore is rarely going to occur after the age of 18. It is aimed at the stage when the subject has officially left and is not an indicator of poor or non attendance in the later years of school.

13 Begun educational/training course since leaving school (First)

14 Begun educational/training course since leaving school (Most recent)

These transitions are restricted to those courses which lead to a recognised qualifiation which should improve prospects within

the job market. They require some effort by the subject and are not those just done for pleasure. If in doubt do not rate. They can be either general, for example, 'O' level English or a more specifically vocational course such as a plumbing apprenticeship. They will principally comprise full-time and day release courses but other evening/day courses are admissable. They do not include any compulsory or brief in-training courses that a subject may attend throughout their job. That is, a decision has to be made by the subject to undergo the training. This transition does not include a driving test.

15 Completed a course since leaving school (First)

16 Completed a course since leaving school (Most recent)

To rate for one of these transitions a subject must have begun an educational/training course as specified above.

For these a subject must have reached the end of the training and, if necessary, taken enough exams or completed enough course work to have obtained some recognized qualification. For example, if a subject originally studied 3 'O' levels, they will have completed this course as long as they have passed at least one of them. If, however, a number of pieces of course work are needed to achieve any qualification and the subject only completes a proportion of that required then the subject would not have reached this transition.

PERSONAL RELATIONSHIPS

In this domain, particularly, top ratings in planning, readiness and desirability must be absolutely what the subject wants. This is to differentiate these subjects from the many people who have vague or non-specific intentions about marriage and children at a future date.

17 Engagement

For an engagement to take place there must be some public acknowledgement that a decision has been made between the subject and partner that a future marriage will take place. There does not have to be an organised event and no date for the wedding has to be set. Only heterosexual relationships are included.

Engagement is always superceded by cohabitation and marriage if they later occur to the same person.

18 Cohabitation - 6 months plus (First)

19 Cohabitation - 6 months plus (Most recent)

To rate as a cohabitation, a relationship must be one in which a couple lives together, regularly eats together, and shares a bedroom/has an estabilshed sexual relationship. Both heterosexual and homosexual relationships are included. To rate in current circumstances, a cohabitation must be of at least 28 days duration with the intention of staying together for longer than six months.

Some situations are ambiguous, especially where people are described as lodgers or housekeepers, but other evidence suggests a sexual cohabitating relationship. A useful guide here may be how the couple present themselves to the outside world, or are treated by others: if they act as a couple, e.g., eat together, share the parenting of children, and visit friends and relatives together, it is probable that they would be rated as cohabiting. If they very firmly insist this is not the case, however, their statements should be accepted unless evidence to the contrary is very strong. Other problems may arise in homosexual relationships.

Similarly another problem for rating is that cohabitations are not always planned as such and no definite decision is made. Instead there may be a more gradual drift into cohabitation and the subject themselves are not even clear about the point at which cohabitation began or if it has or not. Best indicators here are the amount of time spent together and whether the subject or partner has another place to live. For example if one of the partners has given up their rented flat or moved most of their possessions out of the parental home then they are probably cohabiting. Again, if in doubt, use the subject's definition.

A cohabitation must take place at least six months prior to a marriage to count as a separate transition.

An engagement is always superceded by a cohabitation.

20 Marriage (First)

21 Marriage (Most recent)

This transition is always marked by a legal contract of marriage.

If a subject is married to a particular partner then a previous engagement to that person is not rated.

Similarly, cohabitations are only included if they began at least six months prior to the date of the marriage.

22 Separation legal/definite (First)

23 Separation legal/definite (Most recent)

This transition is aiming at the point at which a marriage is clearly over, i.e., when the subject and partner cease to live as a couple and there is an intention by at least one of the parties to end the marriage permanently. As it is often difficult to decide when a separation is temporary or has become a definite and permanent state, the point of legal separation is usually taken. Sometimes there may not be a legal separation but the couple have parted and marriage is clearly over even if one of the parties does not accept this. If at least one month has elapsed since initial separation and no attempt has been made at reconcilliation, where both the subject and partner have taken a part, then the transition has occurred. The degree of involvement at reconcilliation need only be at the cognitive level. In some cases a separation of less than a month may be included if the situation suggests the separation is serious and likely to be permanent. For example, if the subject believed that they had a long, stable relationship and then discovers their partner has had a longstanding affair and decided to leave or if a partner effectively disappears.

It is possible for a subject to undergo the transition of separation and still get back together again with the same partner. This reunion would be a separate transition and may be rated.

Separations can be rated for cohabitations as long as the cohabitation has existed for at least six months with the intention that it would be a longer term committment.

24 Divorce

This transition is only described in legal terms and therefore can only occur when a legal marriage has ended permenantly by a decree absolute.

It is possible to rate this transition and a couple still get back together again. This would be another transition and may be rated.

25 Birth/Becoming a parent (First)

26 Birth/Becoming a parent (Most recent)

This transition applies to both men and women equally. It includes all cases of birth, becoming a step-parent through marriage or cohabitation where the subject has taken on the role of parent of a child under 16. It also occurs in all adoption cases and long-term fostering where the subject is clearly in a role of parent on a permenant basis.

27 Child goes to school (First)

This applies to the stage at which a child attends compulsory education and does not apply to nursery/nursery school.

28 Loss of main responsibility for a child following separation/divorce

This transition will mainly, though not exclusively, apply to men and it is at the point at which cohabitation with the subject's partner ceases as defined in the separation rating. They need not previously have had much involvement with day to day care as long as they had responsibility as a parent. This transition is not directly related to financial responsibility and a subject can still be the main financial provider.

29 Leaving parental home but not financially independent

This transition is aimed at the first break from home though the move does not have to be permanent. However, the intention must be to be away for at least six months and to spend at least 50% of their time living elsewhere. The distance is irrelevant. This transition will mostly occur to those subjects going to college.

If a subject needs money from their parents or family of origin (e.g., grandparents) to maintain themselves then they are not financially independent. The need for financial support should be known about before the subject's departure, and probably be an agreed amount paid on a regular basis. That is, it is not meant to include those situations where a parent ends up helping the subject out in financial difficulties even if this is a frequent occurrence. If a subject is receiving money from another source, e.g a grant, which is dependent on parental income then they are not financially independent. This is because they still require the cooperation of their parents in order to support themselves even if they don't receive any actual money from them.

If a subject leaves home and receives a regular allowance but they do not need this to maintain themselves then they are not financially dependant. This may be difficult to discern but if a subject was forced to greatly alter their standard of living, e.g., move home or sell a car then they are still dependent on their original family.

30 Leaving parental home and complete financial independence from parents.

This transition is to mark a complete and final financial break from the family home. The subject can return at a later date but the intention must be to leave and set up a home elsewhere even if they leave most of their possessions behind.

The subject must not be receiving regular amounts of money from their original family in order to maintain themselves. However, they could be supported by the state, a partner or other source. If the subject receives money from elsewhere which is dependent on their parental income then they are financially dependent and should be rated in the previous section.

This will also include people leaving home to join the armed forces, work abroad or away from home who are financially independent.

31 First mortgage

This transition is described only in legal terms and can only take place on completion of a contract. If the subject has their name on a mortgage, whatever the amount and irrespective of whether they are paying anything, they rate here. If a subject is married/ cohabiting with someone with a mortgage they have not experienced this transition irrespective of any legal claims they may subsequently have.

32 Moving away from area so whole day required for visit

Here we are looking for situations where a subject has moved such a distance that they will have to restart in many areas of their life, i.e., move job, join new clubs etc. Also, apart from those people that may have moved with them, they will have been deprived of the support network from their original area. This transition is not entirely dependent on distance but also on access and the availability of public and private transport. There will therefore be some variability between subjects.

33 Providing for other as sole or main provider (First)

34 Providing for other as sole or main provider (most recent)

This transition is looking at financial responsibilty rather than care. This can occur either when the subject takes on a new responsibilty that did not exist before or, a once shared responsibilty, now falls mainly on the subject. This responsibilty need not be a relative and can be for an adult or child. However, the transition of birth/becoming a parent is rated in preference if it applies.

This transition mainly applies to men when their partners leave work to have a baby/set up home. If a woman takes maternity leave and returns to full time work within sufficient time to have little effect on income then this transition does not occur. If somebody works full-time then a subject would rarely be considered to have become a main provider even if financially this may appear to be the case.

This transition can also apply if the subject takes on somebody who is sick, handicapped or injured. Though this person may have financial income, e.g., a pension, the understanding would be that their standard of living would greatly fall if not for the subject/subject's partner providing for their needs whether financial or care. There should be a relationship between the subject and this person such as relative or friend and it should not include those people who do care taking as their paid employment.

35 Becoming a single parent

This transition applies equally to men and women though will be more common with the latter. It includes all cases irrespective of choice or whether the situation arises from the birth of a child or after a separation. Separation should be as defined in the transition.

TAPI Rating Sheet

F. NR: _____ Sex: _____ d. of int.: _____
Interviewer: _____ Rater: _____

For each domain* of interest, please list each transition separately, so that they can be rated separately.

* Domain: Work 1
Personal Relationships 2
Independent Living 3

Domain	Transition	Age/date	Planned	Readiness	Desirability
1	01. First job				
1	02. Best job				
1	03. Promotion-first				
1	04. Promotion resp.-recent				
1	05. Resp. others-first				
1	06. Resp. others-recent				
1	07. Major change nature of work				
1	08. Starting business				
1	09. Gave up work child-first				
1	10. Gave up work child-recent				
1	11. Becoming working mother				
1	12. Left school				
1	13. Begun education-first				
1	14. Begun education-recent				
1	15. Compl. educ. course-first				
1	16. Comp. educ. course-recent				
2	17. Engagement				
2	18. Cohabitation 6 mts-first				
2	19. Cohabitation 6 mts-recent				
2	20. Marriage-first				
2	21. Marriage-recent				
2	22. Separation legal-first				
2	23. Separation legal-recent				
2	24. Divorce				
2	25. Becoming a parent				
2	26. Birth-recent				
2	27. Child start school-first				

2	28. Loss main resp. child				
3	29. Leav.par.not finan. ind.				
3	30. Leav. par. finan indep.				
3	31. First mortgage				
3	32. Moving away				
3	33. Provider for other-first				
3	34. Provider for other-recent				
3	35. Becoming single parent				

Rating guideline for each domain transitions

Planning:

Definitely planned = 1
Possibly planned = 2
Passive planning = 3
Planning unclear = 4
Definitely not planned = 5
N/A = 8

Readiness:

Completely ready = 1
Partly ready = 2
Unready = 3
N/A = 8

Desirability for subject:

Highly desirable = 1
Partially desirable = 2
Undesirable = 3
N/A = 8

APPENDIX 4.7. THE IMPACT OF STRESS (IOS) INSTRUCTIONS, INTERVIEW, AND RATING SHEET

Background to the Impact of Stress (IOS) Interview:

This measure was created by the staff of the Anna Freud Centre as a means of rating an individual's ability to cope with stress. Each subject is asked to choose one stressful event in the following domains: relationships, friendships, work/school, and family of origin. They describe how they handled the situation 9including how they coped, whether they had somatic symptoms, whether others became involved). The subject's responses to stressful situations are then rated on a four-point scale: excellent, moderate, poor, and very poor.

Should a subject select a stressful situation that is not 'objectively' stressful in LEDS terms (1 or 2), the interviewer gently guides the subject to a more stressful event described earlier in the interview process (i.e., "How did that compare with...."), and then probe about the latter, more stressful event. The IOS questions are asked at the end of each domain covered by the abridged ALPHI/APFA interview. As a result, the interviewer will have had the chance to hear everything that occurred in the domain and help to select the most stressful event. If a subject does not have a severe event in a particular domain, the interviewer should probe for an additional stressful event from an area of life not covered by the above domains.

In order to simplify an d objectify the rating process, each situation described by the subject should be considered cross several dimensions:

1) Complexity: How elaborate or sophisticated is the subject's coping strategy? Does the subject evaluate the cause of the stress in some depth? Dose s/he give sufficient weight to his or her own contribution as well as to the contribution of others?

2) Appropriateness: Did the subject act in a timely manner? Is the strategy suited to the situation? Is it likely that the strategy will have a desirable impact on the stressor

(regardless of the actual outcome), or is it likely to make it worse? Appropriateness should be anchored in terms of potential rather than actual outcome.

3) Activity/passivity: Does the subject ignore or deny the situation? Does s/he face the situation and choose a course of action? Does s/he act impulsively?

These three criteria should be considered together in making a rating score from 1 to 4 (excellent to very poor) for each stressful situation described. After a score is given for each domain, a total coping rating is made. This is not a numerical average. Rather, it should reflect the subject's ability to cope flexibly and specifically vs. rigidly and globally across domains. Thus, if a subject always uses the same strategy no matter what the situation or domain (e.g. mouthing off), the score would be lower than for a subject who uses different strategies foe different domains and situations.

Finally, accompanying each rating on coping should be a rating for the severity of the event or situation described. If the situation received a LEDS rating use this score.

IMPACT OF STRESS INTERVIEW

Note: The interviewer should ask subject to describe the most stressful situation that took place during **the last five years** in each of the following domains: Work, Intimate Relations, Friendships, Family (parenthood or family of origin), or Other if no example can be found in the previous four domains.

I'd like now to ask you about some difficult times you've had in the last five years. You may have described some of these difficult situations previously, but you may choose something which has not come up in the previous interviews. I'd like you to describe the most stressful situation in domain _____, one that you found particularly hard to deal with.

(Interviewer should allow time for subject to think of a stressful situation. If subject cannot come up with an example in this domain, move on to the next one).

Can you tell me what happened and how you responded?

Once subject has described the situation and how they or others responded, probe more specifically for different types of coping strategies such as practical coping (e.g. seeking relevant information or professional help), and emotional coping (e.g. conscious denial, laying down the problem, expressing emotions to oneself or others, etc.).

Probe too for possible lack of coping with the following questions:

How did your body hold up physically to the stressful situation?
Did you tend to get ill, have headaches, stomach aches, back aches?

Did other people tend to get involved to help sort out the difficult situation?

Finally, if not yet established, the interviewer should try and find out whether the stressful situation improved as a result of the subject's or others' response. It is

important to elicit not only the subject's subjective assessment of the situation but also, as much as possible, an 'objective' account of the effectiveness of their (or others') actions.

Did the stressful situation improve in any way? Or get resolved?
Overall, how well do you think you handled the situation? Could it have been resolved differently, perhaps more quickly or more effectively?

Rating notes:
Subject's responses are rated on a four-point scale (1 = excellent coping, 2 = moderate coping, 3 = poor coping, 4 = very poor coping). In addition, an objective rating of severity level is established for each situation, based on the LEDS rating system, and both ratings will be taken into account when ascribing to subjects an overall coping score.

Fol. No. _____ Rater _____ Date of Interview _____
Male/Female
DOB _____

IMPACT OF STRESS RATING SHEET

DOMAIN	SCORE
1. Work Study	N/A
1a. Complexity	
1b. Appropriateness	
1c. Activity/Passivity	
1d. LEDS Severity Score	
1e. Coping Score	
2. Intimate Relationships	N/A
2a. Complexity	
2b. Appropriateness	
2c. Activity/Passivity	
2d. LEDS Severity Score	
2e. Coping Score	
3. Friendships	N/A
3a. Complexity	
3b. Appropriateness	
3c. Activity/Passivity	
3d. LEDS Severity Score	
3e. Coping Score	
4. Family	N/A
4a. Complexity	
4b. Appropriateness	
41c. Activity/Passivity	
4d. LEDS Severity Score	
4e. Coping Score	
5. Other	N/A
5a. Complexity	
5b. Appropriateness	
5c. Activity/Passivity	
5d. LEDS Severity Score	
5e. Coping Score	
6. Overall Coping Score	
7. No. of Stressful Domains Entered	
8. No. Of Domains with 1-2 LEDS Severity	

Fol. No. _____ Rater _____ Date of Interview _____
Male/Female
DOB _____

Note: This rating sheet should accompany a typed transcription of the Impact of Stress Interview.

1. Work/Study Domain

Description:

1A. Complexity:

Description:

Rating Score (1-4) _____

1B. Appropriateness:

Description:

Rating Score (1-4) _____

1C. Activity/Passivity:

Description:

Rating Score (1-4) _____

1D. LEDS Severity Score (1-4) _____

1E. Coping Score (1-4) _____

Fol. No. _____ Rater _____ Date of Interview _____
Male/Female
DOB _____

2. Intimate Relationships Domain

Description:

2A. Complexity:

Description:

Rating Score (1-4) _____

2B. Appropriateness:

Description:

Rating Score (1-4) _____

2C. Activity/Passivity:

Description:

Rating Score (1-4) _____

2D. LEDS Severity Score (1-4) _____

2E. Coping Score (1-4) _____

Fol. No. _____ Rater _____ Date of Interview _____
Male/Female
DOB _____

3. Friendship Domain

Description:

3A. Complexity:

Description:

Rating Score (1-4) _____

3B. Appropriateness:

Description:

Rating Score (1-4) _____

3C. Activity/Passivity:

Description:

Rating Score (1-4) _____

3D. LEDS Severity Score (1-4) _____

3E. Coping Score (1-4) _____

Fol. No. _____ Rater _____ Date of Interview _____
Male/Female
DOB _____

4. Family Domain

Description:

4A. Complexity:

Description:

Rating Score (1-4) _____

4B. Appropriateness:

Description:

Rating Score (1-4) _____

4C. Activity/Passivity:

Description:

Rating Score (1-4) _____

4D. LEDS Severity Score (1-4) _____

4E. Coping Score (1-4) _____

Fol. No. _____ Rater _____ Date of Interview _____
Male/Female
DOB _____

5. Other Domain

Description:

5A. Complexity:

Description:

Rating Score (1-4) _____

5B. Appropriateness:

Description:

Rating Score (1-4) _____

5C. Activity/Passivity:

Description:

Rating Score (1-4) _____

5D. LEDS Severity Score (1-4) _____

5E. Coping Score (1-4) _____

6. OVERALL COPING SCORE (across domains) (1-4) _____

7. Number of domains for which subject gave a stressful situation (out of 4) _____

8. Number of domains which received a severity score (LEDS) of 1-2 _____

APPENDIX 4.8. THE ADULT ATTACHMENT INTERVIEW AND RATING SHEET

Subject_____Date_____Interviewer_____

We're asking people about the kind of parenting they had in childhood. I'll be asking you about your early relationship with your family and what you think about the way it might have affected you. I'll ask you mainly about your childhood, but we'll also get on to your later years and what's going on right now. I'm going to be asking you a number of questions, but I'm not going to be giving you too much direction about how to answer them. I also won't be giving you much feedback during the interview. Take your time. If a question is too hard, you don't have to answer. I hope you'll answer in a way that works best for you.

(1a) Could you start by helping me get oriented to your early family situation, and where you lived and so on? If you could start out with where you were born, whether you moved around much, what your family did at various times for a living?

possible probes if not given spontaneously:

Did you see much of your **grandparents** when you were little?
(If grandparent died before S was born, ask whether S knows how old parent was at time of grandparent's death, what S was told about grandparent).

Were there **brothers and sisters** living in the house, or anybody besides your parents?
Are they **living nearby** now or is your family pretty scattered?

(I b) Would you say **raised you**? (at least 2 & at most 3 attachment figures)

a. _____

b. _____

c. _____

(2) I'd like you to try to describe your **relationship** with your **parents** (those who raised you) as a young child... if you could start from as far back as you can remember.

(3a) Now I'd like you to choose five adjectives that reflect your childhood **relationship** with your **mother** (for main attachment figure) starting from as far back as you can remember, from age 5 -12. I know this may take a bit of time, so go ahead and think for a minute. I'm going to write the **adjectives** down, then I'd like to ask you why you chose them.

possible probe: Take a minute to think more (if <5)

a. _____

b. _____

c. _____

d. _____

e. _____

(3b) Now let me go through some more of my questions about your description of your relationship. You used the word (.....). Are there any memories or incidents that come to mind with respect to your relationship with her being (.....)?

possible probes: No probe if vivid incident; if not, second chance

(4) Now I'd like you to choose five **adjectives** that reflect your childhood **relationship** with you **father** (or second attachment figure) Again, I'm going to ask you why you chose them.

a. _____

b. _____

c. _____

d. _____

e. _____

(4b) Now let me go through my questions about your description. You used the word (.....). Are there any memories or incidents that come to mind with respect to your relationship with him being (.....)?

possible probes: No probe if vivid incident; if not, second chance

(4c) *If more than two primary attachment figures:* Now I'd like you to choose five adjectives that reflect your childhood **relationship** with (the third attachment figure). Again, I'm going to ask you why you chose them.

possible probe: Take a minute to think more (if<5)

a. _____

b. _____

c. _____

d. _____

e. _____

(4d) Now let me go through my questions about your description. You used the word (.....). Are there any memories or incidents that come to mind with respect to your relationship being (.....)?

possible probes: No probe if vivid incident; if not, second chance

(5a) To which parent (or other attachment figure) did you feel the **closest**, and why?

(5b) Why isn't there this feeling with the other parent?

(6a) When you were **upset** as a child, what would you do?

(6b) When you were upset **emotionally** when you were little, what would you do? Can you give me examples of specific incidents?

(6c) Can you remember what would happen when you were **hurt physically**? Again, do any specific incidents come to mind?

(6d) Were you ever ill when you were little? Do you remember what would happen?

possible probes: ask specifically about being **held** by the parent if not mentioned spontaneously
ask about the parent they have not mentioned
get specific examples

(7a) What is the first time you remember being **separated** from your parents?

(7b) How did you and they respond?

(7c) Are there any other separations that stand out in your mind?

(8a) Did you ever feel **rejected** as a child? Of course, looking back on it now, you may realize that it was not really rejection, but do you remember ever having felt rejected in childhood?

(8b) How old were you when you first felt this way, and what did you do?

(8c) Why do you think your parent did those things? Do you think he/she realized he/she was rejecting you?

(9a) Were you ever **frightened** or worried as a child?

(9b) Were your parents or any of the people who raised you ever **threatening** with you in any way - maybe for discipline, or maybe just jokingly?

(9c) Some people have told us, for example, that their parents would threaten to **leave** them or send them away from home. Some people have memories of some kind of abuse. Did anything like that **ever happen** to you, or in your family?

How **old** were you at the time?
Did it happen **frequently**?
Do you feel this experience **affects you now** as an adult? (Does it influence your a
Did you have any of these experiences **by other** people?

(10a) How do you think these experiences with your parents have **affected** your adult **personality**?

(10b) Are there any aspects to your early experiences that you feel were a **setback** in your development?

(11) **Why** do you think your parents behaved as they did during you childhood?

(12) Were there any **other adults with whom you were close,** like parents, as a child? Or were there any other adults who were **especially important to you,** even though they weren't your parents?

possible probes: ages, living with, caregiving responsibilities, nature and significance of relationship

(13a) Did you experience the **loss** (through death) of a parent or other close loved one while you were a young child? (sibling, close family member)?

Could you tell me about the circumstances?
How **old** were you at the time?
How did you **respond** at that time?
Was this death **sudden** or was it expected?
Can you recall your **feelings** at that time?
Have your **feelings** regarding this death **changed** much over time?
Were you allowed to attend the **funeral**? What was it like for you?
What would you say was the **effect** on (**other** parent, family, household) and how did this change over the years?
Would you say this loss has had an **effect** on **your** adult **personality?**
(How does it affect your approach to your own child?)

(13b) Did you **lose** (through death) any **other** important persons during your **childhood?**

repeat queries as above

(13c) Have you **lost other** close persons in **adult** years?

repeat queries as above

(14) Have there been many **changes** in your **relationship with your parents** (or remaining parent) since childhood? I mean from childhood through the present?

(15) What is your **relationship to your parents** like for you **now** as an adult?

(16a) *If subject is a parent*: How do you respond now, in terms of feelings, when you **separate** from your child.

Do you ever feel worried about your child?

(16b) *If subject is not a parent:* I'd like you to imagine that you have a one-year old child. How do you think you would feel if you were to **separate** from the child?

(17) If you had **three wishes for your child** (or future child), twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your child. I'll give you a minute to think about this one.

(18a) Is there any particular thing which you feel you **learned** above all from your own childhood experiences?

(18b) What would you hope your **child** might have **learned** from his/ her experiences of being parented?

SCORING SHEET FOR RELIABILITY TESTING ONLY: COPY AND USE THIS SET FOR ALL AAI RELIABILITY TEST CASES

RATINGS AND CLASSIFICATIONS: CASE _____ JUDGE _____ DATE _____

Scales for Experience	M	F	Other
Loving	_____	_____	_____
Rejecting	_____	_____	_____
Involving/Reversing	_____	_____	_____
Pressured to Achieve	_____	_____	_____
Neglecting	_____	_____	_____

Scales for States of Mind Respecting the Parents (or other persons)

	Mother	Father	Other Person
Idealizing	_____	_____	_____
Involving Anger	_____	_____	_____
Derogation	_____	_____	_____

Scales for Overall States of Mind

Overall Derogation of Attachment	_____	
Insistence on Lack of Recall	_____	Traumatic memory loss? _____
Metacognitive Processes	_____	
Passivity of Thought Processes	_____	
Fear of Loss	_____	
Highest Score for Unresolved Loss	_____	
Highest Score for Unresolved Trauma[1]	_____	
Coherence of Transcript	_____	
Coherence of Mind	_____	

CLASSIFICATION _____

[1] If this score is derived from (a) abuse not directly related to attachment figures or (b) other potentially traumatic events, please note.

Ratings for States of Mind Respecting Primary Childhood Attachment Figures

	Mother	Father	Other Person
Idealizing see esp. pages and lines...	_____	_____	_____
Involving Anger see esp.pages and lines...	_____	_____	_____
Derogation see esp.pages and lines...	_____	_____	_____

Overall States of Mind

Derogation of Attachment (highest score) _____
see esp. pages and lines...

Insistence on Lack of Recall _____
see esp pages and lines...

--evidence for **traumatic memory loss?** see esp pages and lines....

--claims to especially early memories? see esp pages and lines...

Metacognitive Processes _____
see esp pages and lines...

Passivity of Thought Processes _____
see esp pages and lines...

Fear of Loss _____
see esp pages and lines...

COHERENCE OF TRANSCRIPT _____

I. positive elements of coherence/collaboration/narrative
see esp. pages and lines...

II. violations of Grice's maxims

quality
see esp pages and lines...

quantity
see esp pages and lines...

relevance
see esp pages and lines...

manner
see esp pages and lines...

COHERENCE OF MIND _____
see esp pages and lines ....

POTENTIALLY TRAUMATIC EXPERIENCES

Loss of Persons Through Death (include all losses[2])

Person_____ Subject's Age_____ Cause of Death_____ Score for U/d_____
Familiarity with person:
Circumstances:

List all pages and lines where U/d responses are found ...

Person_____ Subject's Age_____ Cause of Death_____ Score for U/d_____
Familiarity with person:
Circumstances:

List all pages and lines where U/d responses are found ...

Person_____ Subject's Age_____ Cause of Death_____ Score for U/d_____
Familiarity with person:
Circumstances:

List all pages and lines where U/d responses are found ...

Include all deaths probed by interviewer (including persons not directly known by subjects, liscarraiges, et alia). If protocol problems exist and disorganized/disoriented speech occurs urrounding a description of a death not well probed, attempt to score and place score in arentheses, noting the protocol problems.

Experiences of Abuse[3] (battering, sexual abuse, other)

Person_____ Subject's Age_____ Type of abuse_____Score for U/d_____
Further description of abuse, including frequency:

List all pages and lines where U/d responses are found ...

Person_____ Subject's Age_____ Type of abuse_____Score for U/d_____
Further description of abuse, including frequency:

List all pages and lines where U/d responses are found ...

Other Potentially Traumatic Events[4]

Event_____ Subject's Age_____ Score for U/d_____

Further description of event/circumstances:

List all pages and lines where U/d responses are found ...

---

[3] Only abuse by attachment figures is presently referenced in the scoring system. Nonetheless include here also e.g., battering and sexual abuse by schoolmates, counselors et alia and attempt full scoring.

[4] Do not be overly inclusive (e.g. do not include peer rejection, normal divorce, or normal boarding school or summer camp experiences, no matter how unpleasant for subject). Include, however, events which would be *overwhelmingly and immediately frightening* for anyone, such as (1) rape, (2) being witness to violence (presently being investigated by Diane Bearman, U. Minnesota), (3) traumatic abandonment/separation (presently being investigated by Ken Adam at U. Toronto), and 4) other events which seem overwhelmingly frightening to this particular subject .

CLASSIFICATION

Classification assigned _____

Narrative summary (Brief narrative case summary re subject's major life experiences--whatever stands out sufficiently to remind you of case in future.)

Explanation of classification assigned. Explanation required in all cases. Fill out completely, use other side of page if necessary.

How well does subject fit to the descriptors for the major Ds, E or F category selected (considered apart from the sub-category)?
Rate from 1 = almost arbitrary, to 9 = prototypic ____

How well does subject fit to the descriptors for the Ds, E or F *sub*-category selected?
Rate from 1 = almost arbitrary, to 9 = prototypic ____

APPENDIX 4.9. THE REFLECTIVE FUNCTIONING (RF) MANUAL AND OUTLINE OF SCORING PROCEDURES (VERSION 4.0)

General Rules: (see p. 14)

1. Only explicitly reflective statements qualify for high ratings (referring to mental states is not enough -- there must a some demonstration of thinking *about* feelings or thoughts).
2. Learned, rote or clichéd statements do not qualify for high ratings.
3. Reference to personality or a relationship, in the absence of specific reference to mental states, does not qualify for high rating. Dynamic explanations and descriptions of personality, however accurate and perceptive they may seem, are not scorable as instances of reflective functioning unless accompanied by specific references to mental states.
4. Giving benefit of the doubt must be carefully avoided. (Need to beware of halo effect here. There is a tendency to give credit for RF when a subject is likable and thoughtful, and this tendency to fill in the blanks in subjects' narratives must be avoided.)
5. Diagnoses should not be accepted as a short-hand for mental states.

Qualities which suggest moderate to high RF: (see p. 8-13)

1. **Awareness of the nature of mental states** (examples on p. 9)
(i.e., passages which demonstrate awareness of their (1) opacity, (2) susceptibility to disguise, and (3) potentially defensive nature; or which (4) demonstrate awareness of the limitations of insight into mental states, or which (5) make explicit reference to commonly expected reactions in specific situations.)

2. **Efforts to tease out mental states underlying behavior** (examples 1-7, p. 10-11)
(Includes accurate attribution of mental states to others, recognition of diverse perspectives, taking into account how our own mental states affect behavior [ours and others'] and perceptions [our own and other's of us], etc.)

3. **Recognizing developmental aspects of mental states** (examples 1-5 p. 11-13)
(Focus here is on how mental states change and evolve, and includes statements reflecting awareness of dyadic and family interactions. Note: awareness of intergenerational influences must contain explicit references to mental states and their influence on interpersonal behavior to count as +RF. Descriptions of interactions without understanding of the role of mental states is not scorable.)

4. **Showing awareness of mental states in relation to interviewer** (ex's 1-3, p. 13-14)
(Credit given for explicit efforts to clarify and help interviewer keep track of material, explicit and accurate references to the likely impact on interviewer of material a subject has provided, statements demonstrating awareness that interviewer may not share subject's mental state in relation to one topic or another.)

Demand vs. Permit Questions: (see p. 25-26)

Demand Questions -- must be rated

(Note: there is no penalty for non-reflective response if speaker has already responded to demand question in answer to previous question):

1. Why did your parents behave as they did during your childhood?
2. Do you think your childhood experiences have an influence on who you are today?
3. (As a probe for influences of childhood experience) Any setbacks?
4. Did you ever feel rejected as a child?
5. (As a probe for losses) How did you feel at the time and how have your feelings changed over time? (Score separately for each loss.)
6. Have there been changes in your relationship with your parents since childhood?
7. Any demand-type question that an interviewer adds in a particular interview (i.e., "And why do you think they did that?")

Permit Questions -- all other questions: Note: Non-reflective responses to permit questions carry less weight than non-reflective responses to demand questions. Highly rated responses, however, should contribute to overall rating.

Guidelines for identifying and demarcating passages:

1. For responses to demand questions, give a single rating for the whole response. Rating should reflect the highest reflective level demonstrated in the response (though statements which are over-analytical or which show signs of negative reflection should be taken into account to reduce overall rating of passage).
2. For responses to permit questions (all other questions), score only if passage would receive a rating of '3' or higher (see below for criteria).
3. Instances of negative RF in response to permit questions can be taken into account when giving an aggregate score, but are not scored separately.

Guidelines for rating identified passages: (see p. 26-30)

Note: All responses to demand questions must be scored, as well as relevant responses to permit questions.

-1 Negative RF (p. 26; examples p. 17-19)

Response must:

1) be given in response to a demand question.
2) be distinctly anti-reflective (i.e., hostile or actively evasive, usually because question is perceived as an assault or attack)

or

bizarre (impossible to understand without making the assumption of irrationality on the part of the subject)

or

inappropriate in the context of the interview (i.e., complete non-sequitors over-familiarity, gross assumptions about the interviewer).

1 **Absent but not repudiated RF** (p. 26-27; examples 19-22)

Response must:

1) be given in response to a demand question.
2) be passively rather than actively evasive.
3) be accompanied by little or no hostility.
4) contain no evidence of:
   a) awareness of the nature of mental states;
   b) explicit effort to tease out mental states underlying behavior;
   c) recognition of the developmental aspects of mental states;
   d) interaction indicative of the awareness of the interviewer's mental state
5) leave the interviewer no better off in terms of knowledge of the mental states of the subject, caregiver or other having read the passage than he/she was before reading it

Response may include:

1) concrete explanations of behavior in terms avoiding reference to mental states (i.e., explanations may be sociological, excessively general, or framed in terms of external, physical circumstances, etc.).

or

2) self-serving distortion (recollections which are highly egocentric, self-aggrandizing and/or contain extraordinarily arrogant claims to insight).

Note: The self-serving quality must be such that it leads the subject to make attributions that are clearly inaccurate and not simply biased or incomplete. Inaccurate efforts to tease out mental states underlying behavior are not sufficient to get a '1' rating unless they are *also* grossly self-serving.

3 **Questionable or low RF** (p. 27; examples p. 22-25)

Response must:

1) contain some suggestion of mentalising efforts on the part of the subject which is nevertheless,
2) devoid of any element that makes reflective functioning explicit (i.e., it never reflects mixed emotions, conflict or uncertainty about beliefs and feelings of others).

Response may frequently:

1) make use of mental state language without making clear or explicit that the subject genuine understands the implications of their statement.
2) appear somewhat clichéd, banal, superficial or 'canned.'
3) be excessively deep and detailed yet unconvincing and/or irrelevant to the task.

5 **Definite or ordinary RF** (p. 28; note: examples for ratings 5-9 are all lumped together under examples of moderate to high RF, p. 8-13)

Response must:

1) contain some feature which makes reflection explicit (i.e., explicit reference to the nature or properties of mental states, how mental states relate to behavior, or mental states in relation to the interviewer).

2) not be a cliché (though it does not need to reflect sophistication).

Response may:

1) show evidence of one of the six features (listed below) for assigning a rating of '7' in the context of a very simple observation of mental states which would otherwise rate only a '3.'

7 **Marked RF** (p. 28-29)

Response must:

1) contain some feature which makes reflection explicit (i.e., explicit reference to the nature or properties of mental states, how mental states relate to behavior, or mental states in relation to the interviewer).

and

2) meet at least one of the following. The passage:
   - is sophisticated (meeting at least 2 categories of qualities which suggest moderate to high RF).
   - is unusual or surprising, casting an original perspective (which is none-the-less readily understandable).
   - is complex or elaborate, described in unusual detail with indication that multiple mental states attributed to a person are considered in relation to one another.
   - places mental states within a causal sequence. Subject considers how the mental states arose, how they influenced behavior and what impact they have on subsequent perceptions, beliefs and desires.
   - provides evidence of an interactional perspective (outlining interactions of mental states between two people or within one person's mind).
   - contains an acknowledgment of a particularly painful situation, with appropriate thoughts and feelings.

9 **Full or exceptional RF** (p. 29-30)

Response must:

1) show the above features of '7 - marked RF' to an usually high degree (i.e., this response would be in the top 10% or less)

or

be given for a particularly charged and emotionally difficult subject in which maintaining even ordinary levels of reflective functioning could be considered exceptional.

2) have a strikingly personal character; it should enable the rater to feel confident that it is experienced as personally significant and meaningful.

Response may frequently:

1) demonstrate full awareness of important aspects of all protagonists within an interaction, such that the protagonists are placed in relation to one another in terms of their feelings and beliefs and these are sufficiently complex and elaborate to convince the rater of their accuracy.

Rules for aggregating RF ratings into overall ratings

General Points:

1) Make a general judgment of the interview as a whole, rather than averaging scores on individual passages.
2) Provide a one-to two-paragraph explanation of the rating highlighting central themes or speech examples they used in making the judgment.
3) When confident that a particular transcript falls between two classes, assign the even number between those classes as an overall rating.

Chart of Overall Rating Criteria

Overall Rating	Common Types
-1 Negative RF • subject systematically resists taking a reflective stance throughout interview. • no passages rated '5' or above • where some '1' or '3' passages exist, consider higher rating.	**A) Rejection of RF** • there are some general indices of neg. RF (i.e., lack of participation, hostility, evasiveness, marked incongruences). • subject responds with hostile refusal to at least 3 demand questions. • if subject gives only one or two hostile refusals, but meets general criteria above, rate '0'. **B) Unintegrated, Bizarre or Inappropriate RF** • mental state attributions are confused and hard to understand. • at least 3 examples of inexplicable, bizarre or inappropriate attributions (may occur in response to demand or permit questions) • must be shocking rather than simply odd.
1 Lacking in RF • reflective functioning is totally or almost totally absent. • mental states may be mentioned, but there is no coherent picture of the subject's or caregiver's beliefs and feelings underlying behavior. • mentalisation is absent in the narrative and awareness of the nature of mental states, if present, not explicit.	**A)Disavowal** • barren accounts, lacking in mentalising detail. • at least 3 examples of assertion of ignorance concerning mental states *or* comparable examples of evasion (physicalistic, behavioral or sociological accounts and global and generalized statements concerning psychological states) in response to demand questions. • no instance of reflective function rated above '3.' **B) Distorted/self-serving** • interview does contain reflection, but reflection is flawed. • reflective passages are egocentric, self-aggrandizing, and self-serving to the point where the accuracy of the representation of the mental state of the other may be reasonably called into question. • at least 3 examples of such purposeful distortions in response to demand questions. • no instance of reflective function rated above '3.'

Overall Rating	Common Types
3 Questionable or Low RF • Some evidence of consideration of mental states throughout the interview, but most references are not made explicit. • Will contain some elements of a reflective stance. • may contain more than 1 example of a rating of '5' or higher. • must contain at least 3 examples of a '3' rating.	**A) Naive/simplistic** • interview shows a partial understanding of intentions of others, but this understanding is likely to be banal, clichéd, and excessively general and superficial. • normalization of experiences extends beyond what is culturally accepted. • interview does not inter into complexities of mental states (conflicts, ambivalence, etc. • naive/simplistic passages are the majority of low ratings. • fewer than 3 ratings of '7' or above. **B) Over-analytical/hyperactive** • The interview may have somewhat greater depth than might be expected in the interview context. • The interview is diffuse, however, and the insights are unintegrated. • There are at least 3 instances in which the subject is over-analytical. • If 1 or more of these includes statements that are bizarre, distorting/self-serving, consider '1' or '2' rating. **C) Miscellaneous low RF** • transcript is neither particularly naive nor overly analytic. • this rating may be a compromise between ratings for transcripts which show marked disavowal mingled with definite evidence of reflective functioning (or other such incongruities).
5 Ordinary RF • There are a number of instances of reflective functioning (and these may be prompted, rather than spontaneous). • Speaker has a model of the mind (own and attachment figures) which may be simple but is relatively coherent, personal, and well-integrated.	**A) Ordinary Understanding** • Subject shows an ordinary capacity to make sense of their experience in terms of thoughts and feelings. • Subject has a consistent model for thoughts and feelings of self and other which requires little or no inference from the rater. • This model is limited, and does not include understanding of conflict or ambivalence. • There are at least 3 passages rated '5.' • No breakthroughs of rejection, bizarre explanations, pervasive disavowal, etc.

Overall Rating	Common Types
5 Ordinary RF (Cont.)	
• Must have at least 1 or 2 clear '5' passages. Most interviews with this rating will have responses in the '3' to '7' range. • If any '-1' or '1' ratings, these are balanced by passages immediately following or elsewhere which indicate reflection.	**B) Inconsistent Understanding** • Certain passages warrant a '6' or '7' rating, but this level of understanding cannot be maintained in relation to one or more problem areas (i.e., a conflictual relationship to one parent). • Even problematic parts of interview do not fall below a '1' or '2' rating.

Overall Ratings for high RF (no sub-types)

7 Marked RF

- Numerous instances of full reflective functioning suggesting a stable psychological model of the mind (own and caregivers') and reactions to mental states.
- Usually, passages where subject has arrived at an original reintegration of states of mind (own and/or others).
- Much detail about thoughts and feelings
- Implications of mental states explicitly spelled out.
- Usually able to maintain a developmental (interactional) perspective.
- In interview as a whole, subject is applying reflective stance fairly consistently to at least one context, or less consistently to a number of contexts.
- At least 3 instances, anywhere in interview, which rate '7' or higher.
- No passages rated '1' or lower.
- No more than 3 passages where rating is less than '5' in response to demand questions.

9 Exceptional RF

- Transcript shows exceptional sophistication, is commonly surprising, quite complex or elaborate and consistently manifests reasoning in a causal way using mental states.
- Shows consistent reflective stance across all contexts.
- Has 3 or more instances, anywhere in interview, with a '9' rating (i.e., the response integrates several aspects of reflective functioning into a unified, fresh perspective).
- Few passages rated '3' and most would be rated '5' or '7.'
- If above criteria are not met but rater "feels" the transcript to be exceptional, a rating of '8' should be considered. (For an '8', should be no more than a couple of passages rated '3' and more than one '9.'

APPENDIX 4.10. THE ORIGINAL LIFE EVENTS AND DIFFICULTIES SCHEDULE (LEDS), THE MINI-LEDS AND RATING SHEETS.

LIFE EVENTS AND DIFFICULTIES INTERVIEW SCHEDULE

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February 1993

INTERVIEW SCHEDULE FOR EVENTS AND DIFFICULTIES

(For use with the LEDS-2; 19/6/89)

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UK.

THE UNDERLINED QUESTIONS ARE THE STANDARD ONES WHICH HAVE TO BE ASKED IF THE POINT HAS NOT ALREADY BEEN COVERED. THE OTHERS ARE SOME SUGGESTED ADDITIONAL PROBES. MATERIAL IN 'BOXES' AT BEGINNING OF SECTIONS ARE SOME SUGGESTED PROBES ONLY FOR USE ONCE AN EVENT/DIFFICULTY HAS BEEN ESTABLISHED.

Note:

i) At the first stage of the depression research, for methodological reasons questions about events were asked separately from those about difficulties; they are now asked about simultaneously.The older procedure can be adopted if required.

ii) The 'questions' are often in the form of a reminder to the interviewer of what to cover in questioning.

iii) This version of the schedule is designed to cover the period from B (the 12-month point before onset, the date of which must have previously been established) up till interview (I). It can, of course, be amended - e.g. in work concerned only with onset and not course so that only the 12-month period from B to C1 (onset of disorder) is covered.

* * * * * *

A. Once an event has been established, question in detail about incidents leading to it, or stemming from it (e.g. decisions preceding a job change or a marriage) in order to establish contextual threat. Use 'boxes' at beginning of sections.

B. Make sure to relate each event to:
i) change-points (e.g.onset case depression),
ii) other events or difficulties.

C. Make sure the respondent knows the range of people routinely included see over).

D. The interview schedule has been phrased for female subjects. The wording will have to be changed in accordance with the sample.

E. Remind the interviewee from time to time during the interview both about these terms and about the period of time to be covered by your particular study.

Now I'd like to ask about the period since.....(IDENTIFY PERIOD AROUND ONSET IF RELEVANT)
and a bit before - that is the period since ...(e.g.'AUGUST 1985').

I'm going to be asking you questions about things that may have happened to you or to people close to you, and by close I mean your:

Husband/boyfriend,
Children (including foster/adoptive children),
Brothers/sisters,
Parents,
Other household members,
Confidants (or main friend if none).

SECTION I - HEALTH

A.

FOR ANY KEY ILLNESS EVENT/DIFFICULTY, SOME SUGGESTED 'PROBES':

FROM DOCTORS:
- Reasons for illness.
- Chances recovery/outlook.
- Treatability.
- Future health; implications for work.
- Has anyone else had it in the family?
- Lack of information from doctor.
- Shortcomings in care.

IMPACT ON:
- Employment; chance of losing job.
- Sick pay; problems obtaining suitable care.
- Manifestations.
- Handicap. How needed to cut down?
- Pain, symptoms.
- How long in bed?
- Interference with everyday life/hobbies/ future plans.
- Had before? Outcome.

ILLNESS OF OTHERS ONLY:
- Was it expected?
- How involved were you?
- Nursing; infectiousness.
- Worry about dying.
- Worry handicap.
- Diet; incontinence; lifting.
- Change behaviour/personality e.g. anger, irritability, ingratitude, blame?
- Stigma/embarrassment?

Has anyone in the family been ill?

What about you?
Your husband or children or parents? (etc)

How serious was it? Was it an emergency?

REFER TO BOX 'A', PAGE 2

Has anyone been admitted to, or left, hospital in the time since... (e.g. 'August 85')

For what?
Was it an emergency?
General/local anaesthetic? How long for?
Problems during hospital stay?

REFER TO BOX 'A', PAGE 2

Have any relatives or close friends died?

What of? (USE BOX 'A', PAGE 2 IF NECESSARY)
Did you expect it?
How often seen before/during illness?
Were you involved at all?
Were you present?
Did you have to comfort the bereaved?
Any problems over arrangements for the funeral, or the will?
Impact on S's way of life.

Has anyone else you know died?

Who? (How long known, how often seen?)

Any surgical operations in the time since ... (e.g. AUGUST 1985) ... to self, child or parent, siblings, friends?

Have you had any bad news about illness that's been going on for some time?

Are there any chronic health problems?
For yourself or close relatives/friends?

e.g. Does anyone suffer from any of the following?:

Any chest troubles.
High blood pressure.
Heart trouble or stroke.
Varicose veins or piles.
Asthma.
Tuberculosis.
Chronic bronchitis.
Gall bladder or liver trouble.
Stomach ulcer.
Any other chronic stomach trouble.
Kidney trouble, or trouble passing water.
Arthritis or rheumatism.
Nervous trouble or psychological disturbance of any kind.
Diabetes.
Thyroid trouble.
Blackouts, fainting attacks or dizzy spells.
Repeated trouble with back or spine.
Chronic skin trouble.
Hernia or rupture.
Epilepsy (or fits).
Migraine.
Trouble with periods, or other gynaecological trouble, or trouble over contraception?

Have you any relatives who are a worry to you for other reasons?
Your close friends?
Because of old age? e.g. dementia; or disability.
Or a drinking or gambling problem?
Mental handicap, or anything else?
How about drugs?

Treatment/official contact re abuse?

In the time since ... (e.g. 'AUGUST 1985') has there been any nervous trouble in the family?

Among your close friends?

Has anyone been referred to a psychiatrist/psychologist?
Or been treated at a psychiatric out-patient clinic, hospital, or child guidance clinic?
What about your husband/parents/siblings?

Has there been any attempted suicide?
Has this ever happened in your family outside this time?

IF DISABILITY IN CHILDREN, ASK:

Do you have trouble obtaining: recognition?
help?
a diagnosis?

What were you told about: outcome?
its implications?
it running in the family?

PROBES CHILD'S DISABILITY:
Effect on behaviour (incontinence/ disturbance).
Effect on personality/ performance (IQ).
Special school? Extra therapy/classes?
IF YES? How long will he/she attend?
Are you worried about managing when he/she grows up?
Have you any plans about this?

IMPACT ON S:
Supervision, care, nursing.
Changing routine/employment.
Chance of a break. Respite care.
Interference with social life.
Special help apart from schooling/therapy.
Help from social services/self-help organisations.
Equipment, modification to home.
Member of supportive association.

REACTION OF HUSBAND/ S'S OTHER CHILDREN/OTHERS?
Relationship with child.
Stigma.

Have there been any accidents?
On the road, or in the home? etc.
What about the children?
Have you been involved in or witnessed any road accidents?

Or anything like that?

How did it happen?
How serious was it? Damage?
Who was hurt?
How far were you involved?
Insurance. Courts.

Has there been any pregnancy in the family, among close friends?

IF YES: Was it planned?
Impact on finance/career plans.
Housing implications.
Complications in previous pregnancy/birth.
Hospital admission.
Spouse/partner's reactions.
Other's reactions.

IF UNMARRIED:
Did you consider termination ... or marriage?
(TAKE ACCOUNT HERE OF RELIGIOUS BELIEFS).

Any miscarriages or abortions?

ASK IF: (i) MARRIED AND 16-45, OR
(ii) NON-MARRIED WOMEN UDER 35 WITH A REGULAR BOYFRIEND IN ... (e.g. AUGUST 1985).
OTHERWISE USE JUDGEMENT:

What about you - have you been pregnant or would you like to have been?

Or worried that you might be?
Did anything go wrong during the pregnancy?

Were any babies born to family or friends?

Complications at birth or afterwards.
Health of baby/mother.
First arrival home e.g. sleeping, feeding.
Other children.
Help in home.

Has anyone lost a baby?

Have any grandchildren arrived?

Has anyone close been trying to become pregnant and had problems with that?

SECTION II - ROLE CHANGES

B.

FOR ANY INTERACTION CHANGE EVENT:

Temporary. How long away.
How often seen before the change?
How much did you do together?
How often do you see now?
Distance.
Telephone contact.
How did you get on? How about now?
Preparation. Evidence rejection/guilt.

INCREASE IN INTERACTION:
How fitted in - space/tension.

C.

FOR ANY MARRIAGE/ENGAGEMENT INVOLVING S:

How long known.
Complications/'delaying tactics'/rejections.
Family reactions.
Was there anything about him made you uneasy?

Has anyone in the family got married in the time since ...
(e.g. 'AUGUST 1985')?

What about your brothers, sisters, parents, children, friends?

*** REFER TO BOX 'B' ABOVE ***

Anyone engaged?

What about your brothers, sisters, parents, children?

When was this? When was it decided?
When was it first made more official?
Was it expected?

Has anyone close retired for good e.g. husband, parents?

Was this expected?
What changes did it bring? e.g. financial, routine changes, etc?

Or has anyone separated from or divorced their husband or wife?

Were you involved at all?
Did you expect it to happen?
What about your brothers or sisters?

D.

FOR ANY DIVORCE/SEPARATION INVOLVING S:

Reasons.
Preparation; anticipation.
Who left? What circumstances.
Forced to leave.
Anyone else involved.
'Alternative' relationship by either spouse.
Finance/housing.
Custody.
Children - their reactions etc.
Clean break/pestering/violence.
Family's reaction.
Legal advice. When.
Maintenance arrangements.
Often seen now.

Anyone started school or college e.g. begun school for 1st time?

Gone away to University?

How did you feel about this?

Has anyone taken any important examinations or qualifications?

What were the results?

SECTION III - LEISURE AND INTERACTION

Have you made any new friends, of either sex, at all?

ASK ABOUT NEW OPPOSITE SEX RELATIONSHIPS.

Have you lost someone you were close to - either because they've moved away, or died, or just drifted apart?

ESTABLISH WHY. IF LOSS OF BOYFRIEND, PROBE ABOUT WHAT HAS HAPPENED TO HIM SINCE THEN.

IF RELEVANT - ANY PROBLEMS WITH SEX, UNRELIABILITY OF PARTNER CONTRACEPTION.

Have there been any big changes in the amount you see of your friends or relatives?

ASK IF APPROPRIATE:
Do you have a boyfriend at all?

FOR SINGLE, SEPARATED OR WIDOWED SUBJECTS: (USE TACT!)

Have you thought of getting engaged or married?
i.e. in the last year or to someone in past years.

How long ago was this? Do you have any regrets about it now? What happened?

Would you like to get married, do you think?

ASK EVERYONE:

Have there been just the ... of you at home during the time since ...(e.g. AUGUST 1985)?

Has anyone come to stay?

IF YES: For how long?
Was that how long you expected them to stay?

Has anyone left the household at all?

IF YES: Permanently?

Is there anyone you see much less of?

IF YES: Why is this? Do you miss them?
What difference has it made to you?

Have there been any changes in the way you spend your leisure time?

Do you feel that you have enough leisure time?

IF YES: Are there things you'd like to do, but can't?
Why is this, e.g. short of money, transport, babysitters, etc?

Do you invite friends home at all?

Have you had any difficulties with friends?
Or been worried about them?

Have you had a holiday since ... (e.g.'AUGUST 85')?

IF YES: How did it work out?
Did you have a good time?
Did anything unexpected or important happen when you were away..... or on your return?

SECTION IV - HOUSING

Have you moved since... (e.g. AUGUST, 1985)?

E.

FOR ANY RESIDENCE CHANGE EVENT, PROBE:

Why did you move? What happened?
Decision to move.
Were there any difficulties?
Have there been any since then?
Expense.
Consequences.
Did you feel cut off? Baby-minders etc.
New friends.
Impact on job.
Problems re house/neighbours etc.

How long have you lived in your present home?

Do you own it yourself?

IF NOT: ESTABLISH TYPE OF HOUSING. PROBE FOR SECURITY OF TENURE.

Do you like living in your present house/flat?

Can you tell me if any of the following have been a problem?

Have you got enough room?

IF NOT ALREADY KNOWN, OBTAIN NUMBER OF ROOMS, EXCLUDING BATHROOM. KITCHEN = 1, IF BIG ENOUGH TO HAVE MEAL IN.

Sharing facilities? Self-contained?

Do you feel it's private enough?

ASK ABOUT SHARING BEDROOMS IN FLAT-SHARES.

Trouble with repairing the house etc?

Anything wrong with roof...
.... dry rot.... damp walls.... rats, etc.

ASK ABOUT PROBLEMS WITH GETTING IT DONE, PAYMENTS ETC.

Have you approached the landlord/Council about this?

What about facilities for the children playing?

Have there been any problems with the landlord?

Any restrictions?
..... that sort of thing?

ASK WHERE RELEVANT: Does this affect you?

Have there been any problems, that you know of, about paying for the house, keeping up with the rent/mortgage?

What about with others in the flat/house? How do you get on?

Any difficulties?

What about the neighbourhood? How do you get on with the neighbours?

Have there been any difficulties with them?
Have you fallen out with any neighbours in the flat/house?
What about noise in the house/neighbourhood?
Does it affect you?

Have you ever felt cut off in your present home - too far from friends or work/school?

Have you considered living anywhere else?

IF YES: What have you done about it?

IF RELEVANT, PROBE UNCERTAINTY OF E.G. MOVING, OR LIKELIHOOD OF LEAVING HOME.

Do you or your family have a telephone? A car? Do you drive?

SECTION V - EMPLOYMENT AND SCHOOL

F.

IF ANY IMPORTANT CHANGE ESTABLISHED, FIND OUT:

- How came about, whose decision.
- Financial implications.
- Convenience, hours etc.

IF FOR S:

- Travel, babysitting/ arrangements for children.
- Responsibility/demandingness.
- Interest; importance.
- Plans for future.

A. FOR SUBJECT:

Do you enjoy your job/school/college?

Has anything happened at work/school/college?

Have you been off work/off school/college at all?

Or put onto a new job/course, or changed job/courses?

Any promotions?

Has anyone you worked with closely left in this time since ...?

IF YES, PROBE:

Seen regularly and frequently at work.
Extra-work involvement/ seen out of work hours?
Close relationship required by job?
Effect on subject's job?
Extent of separation.

How do you get on with your workmates/ schoolmates/ collegemates?

Have you had any trouble or difficulties with them?

Were there any other difficulties at work/school/college?

PROBE FOR EVENTS OR LONG TERM DIFFICULTIES

Long hours, low pay, travel,
short-term or temporary contracts, etc.

What do you like about your job/school/college?
Is there anything you don't like about it?

Promotion prospects.
Responsibility.
Wages.

Is there another work/school/course that you would have liked better?

IF YES: Why?

Have you felt that the demands made on you at work/ school/ college were too great?

Deadlines to meet.
Not enough training/information.
Bad physical conditions.
Moving from job to job if a temporary employee.

Have there been any times in your work/at school/college when you didn't know what was expected of you?

For instance when one person wants you to do one thing and someone else wants you to do something different?

e.g. supervisors/teachers, colleagues/fellow pupils, juniors.

WORK HISTORY FOR LAST 12 MONTHS:

Why left, when arranged, etc.
Any time off through sickness/
redundancy / strike?
Preparation
Chances of new job. What kind.
Impact on home life - actual/likely.
Impact on S's household.

Has .... had any promotion in the job?

Does .... have any problems in the job at all?

Is he/she a trade union member?
If your husband/boyfriend/father lost his job, how easy would he find it to get another?
Has he/she any qualifications or special skills?

C. OTHER IMPORTANT HOUSEHOLD MEMBERS.

Has ..... been off work at all in this time?

COLLECT PERIODS OF UNEMPLOYMENT LASTING 4 WEEKS OR MORE.

SECTION VI - FINANCIAL

Have you had any money worries in the time since...(e.g. 'AUGUST 1985')?

Have you had to borrow off anyone?

GET DETAILS OF DEBTS OR LOANS

Does anyone borrow money from you?

Have you gone without things you really needed?

Are you (or have you been) receiving social security or unemployment benefit?

Any problems with state benefits?

IF THERE ARE ANY DIFFICULTIES:

Have you ever thought of asking to be transferred to another section/department/class?

Have you been expecting any changes in your job/at school/ college?

Are you a member of a trade union?
Do you get proper sick pay when ill?

How do you feel about the future, do you think you'll stay in this job/ until the end of school/ college?

Might you leave for any reason?

*** REFER TO BOX 'F' (PAGE 12) ***

IF RELEVANT, ASK FOR THREAT OF HAVING TO GIVE UP WORK FOR ANY REASON.

How important is it for you to do well in this job/ course?

IF RELEVANT, ASK ABOUT UNCERTAINTY OF:

Chances of promotion,
or graduation,
time duration of promotion,
or of student or trainee role.

Have you done different types of work in the past?

Have you ever in your life had to give up a job, or been dismissed from a job?

DO NOT FORGET THAT STUDENTS ALSO OCCASIONALLY HAVE SATURDAY/ PART-TIME JOBS WHICH MAY BE THROWING UP EVENTS AND DIFFICULTIES AS WELL AS THEIR SCHOOL/COLLEGE.

B. IDENTIFY CRUCIAL WAGE-EARNER IN HOUSEHOLD (if not S).

Has your husband/boyfriend/father (crucial wage earner) been working all this last 12 months?

Have you got into arrears?

Rent, gas, electricity,rates.

How much do you owe?
Have any of the services been cut off?
Any letters threatening you with eviction or taking you to court?

Have you had any difficulties with credit facilities at all?

Anything repossessed by hire purchase companies?
What about any problems with health insurance?
Do you have a life insurance at all?

Did you have to cut down on anything in that time?

SECTION VII - MARITAL

(INCLUDES COHABITEE AND SERIOUS BOYFRIEND)

FOR THOSE MARRIED/COHABITING:

Have you and your husband/boyfriend both been living at home during this time?

IF YES:

So you've not been separated for any length of time during this time?

Have either of you ever considered a permanent separation or divorce?
When? Why?

*** IF RELEVANT REFER TO 'BOX 'D' (PAGE 8) ***

How well would you say you and your husband/boyfriend get on in general?

Would you say there are any problems about your relationship?

Has anything happened that has made you feel differently about the relationship?

How often do you and he/she have quarrels or tiffs?

Have there been any serious quarrels since....(e.g. AUGUST, 1985)

IF YES:
What are they usually about?
e.g. disagreement about marriage, money etc.
What happens during a quarrel?
Is there any shouting or throwing things?
Does either of you hit the other?

IF YES:
Has there been any injuries?
What happened?
Has this happened before?

Do you feel you can talk to him quite easily?
Do you talk to him/her about things that worry you?
Do you wish you could confide more in him?

Has this changed since.... (e.g. AUGUST, 1985)

When he has problems or worries does he talk them over with you?

Is your husband/boyfriend and affectionate person.... is he demonstrative?

Do you like doing the same things when you are together?

How do your parents get on with him?
And your family?
And what about his parents - do you get on with them?

PROBE FOR ANY TENSION, EG CULTURAL DIFFERENCES

What about the sexual side of things - have there been any difficulties or problems about this?

Do you ever refuse to have sex?

IF YES: Has this created any problems?
Has he ever forced you to have sex?
What happened?

Any problems with contraception?

IF RELEVANT: ASK ABOUT 'UNPROTECTED SEX'.

As you know in some relationships one of the partners sometimes gets involved with another person, has that ever happened to either of you?

IF PARTNER: When?
How did you first find out about it?
How did things work out?
Does he still ever see that person?

IF S: When was that?
Did your husband/boyfriend find out?
How did things work out?

FOR DIVORCED AND REMARRIED WOMEN WHERE RELEVANT ASK:

Do you ever have contact with your ex-husband?

Have there been any difficulties with him over this?

Any legal or custody problems?

FOR SINGLE MOTHERS ASK:

Continued relationship with husband.
Problems with children e.g. behavioural, in relation to husband.
Stigma.
Loneliness.
Sexual relationships with men
Financial hardship.
Practical help with childcare (school holidays, babysitting, illness).

FOR WOMEN LIVING ALONE: ASK ABOUT ANY SEXUAL RELATIONSHIPS SINCE ... (e.g. AUGUST, 1985).

Any problems e.g. fidelity, sex, unreliability partner?

SECTION VIII - INTERACTION WITH PARENTS AND OTHER RELATIVES

How well do you get on with your parents?

FOR S'S MOTHER: (TO BE REPEATED LATER FOR FATHER, SIBLINGS)

A. IF OUTSIDE THE HOUSEHOLD:

Have there been any changes in how you get on/the amount you see of your mother/or how you feel about her since... (e.g.'AUGUST,1985')?

IF YES: What difference has this made to you?

B. FOR ALL:

Would you say there's been any tension or difficulty between the two of you?

Do you avoid her....or try to keep out of her way?

Have you felt you could confide in her?

IF YES: Do you find it helpful to talk things over with her?
IF NO: Would you like to be able to confide more in her?
Has this changed?

C. FOR THOSE LIVING WITH MOTHER:

Have you felt that you had to tell your mother about things you do?
For example, do you feel you must tell her where you're going - or if something happens to you like a rise in pay?
Does she like to have a big say in your life - e.g. about the clothes you wear, and your friends, and where you go out?

PROBE FOR INTERFERENCE

IF RELEVANT:
What about your school work - did she put you under much pressure about that?
What about compared to your brothers/sisters/ cousins?
Does she often compare you with other people of your age whom she knows - like her friends' children?
Did she have her own plans about your future or is she leaving it up to you?
How do you feel about this?

REPEAT ABOVE QUESTIONS FOR FATHER,
AND FOR EACH SIBLING OR OTHER RELATIVE WITH WHOM RESPONDENT LIVED DURING THE STUDY PERIOD.

ASK FOR EVERYONE:

How would you say your parents have got on together?
Are there any difficulties between them?

Did/do they quarrel at all - or have periods of not speaking to each other?

Have they worried you at all?

SECTION IX: CHILDREN (IF RELEVANT)

How would you say you get on with your children in general?

Do you ever have quarrels, or are they quite easy?

IF CHILDREN YOUNG: Any problems over baby-minding? PROBE FOR TENSION ETC WITH NANNIES.

IF CHILDREN OLDER: How are they getting on at school?

Do you ever worry about the friends they keep company with or the things they might get up to in their spare time?

Any worries about them smoking, taking drugs?
Or stealing?
Or about sex?
Or about anything like that?

Have you discovered anything about them that has surprised or shocked you?

IF RELEVANT:

Are you happy about their boyfriends/girlfriends?

IF ANY DISABILITY AND NOT COVERED EARLIER IN CHILD'S HEATH SECTION I (PAGE 4).

SECTION X - CRISES

G.

FOR ANY COURT APPEARANCE EVENT:

Nature of offence.
First time done it.
First time in court.
Other convictions.
Verdict. Sentence.
Financial implications.
What have other people said?
What have they said at work?
Driving affected (if licence lost etc).
Implications re other people involved.
Were you afraid they would try to get their own back?

H.

FOR ANY BURGLARY OR LOSS OR DAMAGE TO PROPERTY:

How did it come about? (S's 'fault'?)
Did you see the burglar?
How much was taken?
Problems with insurance.
Anything irreplaceable.
House damaged.

In the time since ... (e.g. 'AUGUST 1985'), has there been any crisis/emergency?

Any crisis involving your husband/children/parents/brothers/sisters, etc.?

Has there been anything in the home?

Such as a burglary or fire?

Or being attacked in the street?

Has that ever happened to you?

Or have you ever been sexually approached by anyone against your will?

IF YES: What happened?
Were you hurt?
Were the police involved?

Have you had to break any bad news to anyone?

Have there been any legal troubles, or having to go to court?

Contact with a solicitor?

IF YES: What about?
What happened?

Have you or anyone in the family had any involvement with the police or courts or prison at all?

IF YES: What about?
What happened?

Or any contact with any social agency.... social worker..... ....welfare officer.... marriage guidance counsel.... probation officer?

What about your brothers or sisters, parents, children, friends?

Have any of your relatives had any crises or troubles with which you've had to help.... e.g. has anyone gone to stay with an ill relative?
Or any in which you've been involved?

What about friends?
Have there been any troubles or difficulties concerning them in the past year you've not already mentioned?

MENTION EACH OF CLOSE TIES BY NAME

Have you lost any pets?

IF LOSS OR 'DAMAGE' TO PET, ASK:

How long have you had it?
How did it happen?
Did you see it? (PROBE FOR GUILT)
Have you thought about getting another?

IF RELEVANT: (FOR 'FOREIGNERS')

Have you had any problems connected with living in this country rather than at home?

PROBE FOR IMMIGRANT VISAS, NATURALISATION OR CHANGE OF NAME.

Sometimes people learn unexpected things about others close to them, such as discovering that their child has been stealing at school, or that their husband/wife has been having an affair, or their boyfriend/girlfriend has been seeing someone else. Have you had anything like this?

News that shook you at all?
Anything like that that made you change your idea of a person's character?
Seeing something in a newspaper which shocked you about something personal?

SECTION XI - FORECASTS

Have you or any member of the family had unexpected news in the time since ...(e.g. 'AUGUST, 1985') about anything that has happened or is going to happen?

For example, sometimes a family will get a letter saying they are going to be re-housed.... or they might perhaps get notification of redundancy.

Anything like that?

GIVE TIME TO THINK.
REFER TO POSSIBLY RELEVANT EVENTS ALREADY ESTABLISHED.

SECTION XII - GENERAL

I have asked a good many questions about changes in the period since ...(e.g. AUGUST 1985) - have there been any changes of any importance to you that you've not mentioned?

Has anything particularly disappointing happened during that time that you haven't mentioned already?
.... like a child failing an exam?

Have you had to make any important decisions over this time?

You will have gathered by now that we're interested in anything upsetting, important or exciting that has happened to you.... exciting in a pleasant or unpleasant way.
Has anything given you special pleasure?

IF YES: A visit from a relative.
Meeting someone.
A holiday.
A child winning a prize.
A present, a new car, etc.

Anything turned out better than expected?
Financial windfall?
Relationships improving in some way?

Now this is a bit of an odd question I'm afraid, but we do ask everyone:

Is there anything about yourself you feel self-conscious about?
.... Your appearance?
.... The way you do things?
.... Anything like that?

In your life so far: Are there things you wish had turned out differently?
Or any regrets you have?
.... Over education, training?
.... Over marriage?

[END OF SCHEDULE]

THE ANNA FREUD CENTRE
LONG-TERM FOLLOW-UP STUDY

MINI-LEDS INTERVIEW PROTOCOL

April 1996

SHORTENED LIFE EVENTS

Now I'd like to ask you about things that have happened to you in the last - 5 years.
FOR ALL DIFFICULTIES ESTABLISH WHEN THEY STARTED AND WHETHER THE LEVEL HAS CHANGED.INDICATE THAT QUESTIONS RELATE TO CORE CONTACTS, FAMILY MEMBERS AND HOUSEHOLD MEMBERS, I.E. NAMES ON CHECKLIST.

Illness (Q 1) — Have you or anyone in your family had any illness worse than colds or flu ?

(IF YES, PROBE: How long did it go on for ? What have the doctors said about it?)
PROBE FOR LONG TERM IMPLICATIONS; TIME OFF WORK ETC.

Illness (Q 1/2) — Has anyone been admitted to hospital or had an operation ?
(IF YES, PROBE: How serious was it? Was it an emergency?)

Accident (Q 2) — Have you or anyone been attacked in the street or in the home?
(IF YES, PROBE: What happened ? How serious was it?)

Have you or anyone in your family had an accident on the road or in the home?
(IF YES, PROBE: What happened? How serious was it?)

Death (Q 3) — In the last year has anyone close to you died ?
(PROBE: Was it unexpected ? Were you involved at all?)

Has anyone attempted suicide?

Marital (Q 4) — Have you had any problems in your marriage in this time that you haven't already mentioned ?

(PROBE: Have you been separated for any length of time in the last year ?)

Rows (Q 5) — Have you lost contact with anyone who used to be close?
PROBE FOR VCO'S AND CONFIDANTS.

Is there anyone whom you see much less of than you used to?
PROBE FOR VCO'S AND CONFIDANTS.

Have you ended any relationship in the last year?
PROBE FOR VCO'S AND CONFIDANTS.

Have you had any other sort of crisis in the family -such as a major row with a relative ?
Have you made any new close friends in the last year of

either sex?

Have you had any financial problems or been in debt ?
(PROBE: What about paying the rent, have you had any problems with that ?)

Have you or anyone in the family got engaged or married?

Has anyone broken off an engagement, been separated from their husband or wife, or been divorced?
(IF YES, PROBE: Were you involved in any way ?)

Have any of the children started or left school?

Has anyone taken any important exams ?
(IF YES, PROBE: Did they go O.K ?)

Has anyone gone to University or started a new course?

Pregnancy (Q 6) Has anyone in the family or your girlfriend been expecting a baby,or had a baby?

(IF YES, PROBE: Was it planned ? Did the birth go smoothly?)

Miscarriage (Q 7) Any miscarriage, abortion or stillbirth?

Work (Q 8) Have you or any household member been made redundant or retired?

(IF YES, PROBE: Was this expected ? Has it caused any financial problems ?)

Have you or any household member been unemployed ?
(IF YES, PROBE: For how long ? Did it cause serious financial problems?)

Have you or any household member started a new job or had a major change at work in the last year ?

Have you had any problems at work over the last year that you have not already mentioned ?

Have you had any problems at school or college?
(Probe:with course work, fellow-students, teachers)

Police/ court (Q 9) Have you or anyone in your family had any contact with the police or a solicitor or court ?

Housing Have you had any problems with your housing or neighbours?

(Q 10) (IF YES: PROBE: Have you been rehoused or put in a rehousing application because of it?)
Have you had any big disappointments ?

Have you or anyone in the family had important news about something that's going to happen ?
(PROBE: Such as rehousing ? or notice of redundancy?)

Children/ Have the children had any problems at school that you've not already mentioned - such a truancy, for example; or have they been a problem at home?

Revelation
(Q 11)

Sometimes people learn unexpected things about others close to them, such as discovering their friend has been stealing, or their girlfriend has been seeing someone else - has anything like this happened to you ?
(Probe: something that changes your idea of a persons character?)

Miscell Have you made any important decisions?
(Q 12)

Have you had to break any bad news?

Have you had any burglaries or a fire or flood ?
Has anything valuable been lost or stolen outside the house?
Have you been involved in a fight ? Was it someone you knew or a stranger?

What happened? Were the police involved at all?

Have you ever been arrested or had to go to court because of a fight?

Have you ever been in a relationship where you or your partner has been physically violent towards one another?

When did it start? What actually happened?

Were the police ever involved?
IF S EVER VICTIMISED ESTABLISH DEGREE OF VIOLENCE
Pushing? Shoving? Kicking? Hitting with object?Punching?
Burning? Choking?
ESTABLISH DEGREE OF INJURY
Bruises? Cuts? Burns? Broken bones? Hospital treatment?

LIFE EVENTS RATING FORM

ID NUMBER:

EVENT NUMBER (E1)

CLASSIFICATION NUMBER (E3a)

DATE OF EVENT (E2a)

INDEPENDENCE FROM HYPOTHETICAL DISORDER (E4b)

Independent

- 01 Totally independent
- 02 Nearly totally independent
- 03 Possible influence from subject, but unlikely (possible negligence)
- 04 Independent - involves S's physical illness

Possibly Independent

- 05 Compliance of subject with external situation (consent)
- 06 Intentional act by S
- 07 Probable negligence/carelessness on S's part
- 08 Arguments/tension/rows/end contact
- 09 End contact, no argument
- 10 S's love/sex event
- 11 Partner's love/sex event
- 12 Illness related
- 13 Related to drink/drugs

FOCUS (E5)

0 Subject	3 Family member
1 Household member	4 Other person
2 Joint	5 S's possession or pet

THREAT (E6/E7/E8/E9)

Short-term threat contextual 1-4
Short-term threat reported 1-4

Long-term threat contextual 1-4
Long-term threat reported 1-4

NEW CLASSIFICATION OF THREAT (E10)

If event is 2 on long-term contextual threat and S or J focussed, then rate "a" or "b":

1 Upper moderate threat (a)
2 Lower moderate threat (b)
-1 Not a 2S or 2J event

INDEPENDENCE FROM PERSON (LC1)

1 Independent	(100%)	5 Probably dependent	(20%+)
2 Mainly independent	(80%+)	6 Mainly dependent	(1%)
3 Probably independent	(55%+)	7 Dependent	(0%)
4 Internal/external equal	(45-55%)		

INDEPENDENCE FROM FAMILY MEMBERS INCLUDING ALL FIRST DEGREE BIOLOGICAL RELATIVES (EXCLUDING SPOUSE AND OWN CHILDREN) (LC2)

1 Totally independent
2 Likely to be independent
3 Dependent on relative or directly linked with relative

DIFFICULTIES RATING FORM

ID NUMBER:

DIFFICULTY NUMBER (L1)

CLASSIFICATION NUMBER (L2)

MONTH AND YEAR DIFFICULTY BEGAN (L3)

MONTH
YEAR

DURATION OF DIFFICULTY (MONTHS) (L4)

SEVERITY MAIN PERIOD (L5/L6)
CONTEXTUAL SEVERITY
REPORTED SEVERITY

FOCUS (L7)

0 Subject	3 Family member
1 Household member	4 Other person
2 Joint	5 S's possession or pet

INDEPENDENCE FROM HYPOTHETICAL DISORDER (L8)

Independent
- 01 Totally independent
- 02 Nearly totally independent
- 03 Possible influence from subject, but unlikely (possible negligence)
- 04 Independent - involves S's physical illness

Possibly Independent
- 05 Compliance of subject with external situation (consent)
- 06 Intentional act by S
- 07 Probable negligence/carelessness on S's part
- 08 Arguments/tension/rows/end contact
- 09 End contact, no argument
- 10 S's love/sex event
- 11 Partner's love/sex event
- 12 Illness related
- 13 Related to drink/drugs

INDEPENDENCE FROM FAMILY MEMBERS INCLUDING ALL FIRST DEGREE BIOLOGICAL RELATIVES (EXCLUDING SPOUSE AND OWN CHILDREN) (L9)

1 Totally independent
2 Likely to be independent
3 Dependent on relative or directly linked with relative

DIFFICULTY LINK TO CODED PLAN (give number of plan) (L10)

LINKS WITH DIFFICULTIES (LC3)

0 Event is not linked to difficulty
1 Event is linked to one difficulty
2 Event is linked to two or more difficulties
8 N/A

ID NUMBER _____

RATER _____

THE ANNA FREUD CENTRE LONG-TERM FOLLOW-UP STUDY

LIFE EVENTS RATING FORM

Note: Rate all events chronologically.

Description	Event No. E1	Class. No. E3a	Date Event E2a	Indepen-dence E4b	Focus E5	S-T Threat-C E6	S-T Threat-R E7	L-T Threat-C E8	L-T Threat-R E9	New Class E10	Indepen Person LC1	Indepen Family LC2	Links w/ Diffic LC3

ID NUMBER _____

RATER _____

DATE OF INTERVIEW_____

THE ANNA FREUD CENTRE LONG-TERM FOLLOW-UP STUDY

LEDS DIFFICULTIES RATING FORM

Note: Rate all difficulties chronologically. Difficulties that change in severity should be rated on multiple lines. First rating L1, L2, L3 etc. Change in severity indicated by L1a, l1b, L1c, etc. And if there is yet another change, L1c, L2c, L3c, etc.

Description	Diffic. No. L1/L1a/L1b	Class. No. L2/L2a/L2b	Date (mo/yr) L3/L3a/L3b	Severity-C L5/L5a/L5b	Severity-R L6/L6a/L6b	Focus L7/L7a/L7b	Indep L8/L8a/L8b	Indep Family L9/L9a/L9b

APPENDIX 4.11. THE ADULT LIFE PHASES INTERVIEW (ALPHI) RATING SHEET AND PARTNER RECORD

PHASE NUMBER _____

BRIEF VERSION

ID _____

RATER _____

Rate all adult phases from end of childhood giving consecutive numbers

Summary description of phase.

Date of start of phase
(Put 17th birthday for beginning of 1st phase if still in parental home.)

E1 _____
DD MM YY

REASON FOR CREATING PHASE RECORD

(rate in terms of hierarchy)

0. Change of partner
1. Change in living place/arrangements
2. Marked change in goal directed behaviour re self-advancement (e.g. returning to education or retraining)
3. S aged 17+ but still in parental home (i.e. no real change from childhood arrangements)
4. Other

E2A_____

0. No, launching point
1. Yes, launching point

E2B_____

EMPLOYMENT & SOCIAL CLASS

Type of employment during phase

1. Working (nearly) all of phase; full-time
2. Working (nearly) all of phase; part-time
3. Working (nearly) all of phase; mixed
4. Working at least half of phase; full-time
5. Working at least half of phase; part-time
6. Working at least half of phase; mixed
7. Working less than half of phase
8. Occasional working
9. Not working

E3A_____

SOCIAL CLASS

S's peak job during phase (H-G 35 points)
-1 never worked

E3B _____

S's lowest classified job (H-G 35 points)
-1 never worked

E3C _____

S's ascribed social class during phase (H-G 35 pts)
This is based on (in order of precedence)
i) husband/cohabitee's occupation if applicable;
ii) father's occupation if still living with parents;
iii) her own occupation.

E4 _____

PARTNERS

Number of cohabitees/spouses during this period

E5 _____

Number of boy/ girlfriends during this period
(Non-cohabiting, but regular contact; exclude any in E5)

E6 _____

Number of casual sexual partners (not already included)

E7 _____

0. None
1. Few (1-5)
2. Several

SUPPORT

Did S have a confidant seen monthly during this period?
0. No.
1. Some of time.
2. Most of time.
3. Variable

E8 _____

Date when no confidant:
Rate periods when no confidant (do not include partner relationship)
If more than one, rate first and longest period.

1ST OR LONGEST: beginning E8A _____
DD MM YY

end E8B _____
DD MM YY

2ND OR LONGEST: beginning E8C_____
DD MM YY

end E8D_____
DD MM YY

S's level of role involvement during phase Rate the degree of S's involvement and behavioural commitment to the following roles or areas of life. Reflect predominant behaviour during phase.	
PARTNER ROLE 0. Low/ nil Has no partner. 1. Partial: Sees boy/girl friend regularly or intermittently, but not cohabiting and seen less than daily. Has partner for only small proportion of phase. 2. Full: S is cohabiting for most of phase, or has a number of boy/girl friend relationships.	E9____
PARENT ROLE 0. Low/nil: S has no children and is not actively trying to get pregnant, adopt etc. S has lost contact with children. 1. Partial: Children have left home and seen less than daily. S separated from young children but seen weekly or fortnightly. 2. Full: Children at home or seen daily - S very involved.	E10____
HOMEMAKING ROLE 0. Low/nil: lack of involvement in running household. 1. Partial: some homemaking activities but others take on most of responsibilities, or these are not required (e.g. in lodgings). 2. Full: considerable time/effort/resources expended by S	E11____
WORK ROLE 0. Low/ nil: S does not work and is not looking for a job. 1. Partial: S works part-time or is actively looking for work. 2. Full: S works full time and is committed.	E12____
DAUGHTER/ SON ROLE 0. Low/nil: Little or no contact with parents. 1. Partial: Limited or irregular contact with parents (e.g. every few months or so 2. Full: High degree of contact e.g. fortnightly or more.	E13____

GRANDPARENT ROLE 0. Low/nil: S has no grandchildren or no contact with them 1. Partial: Some contact with grandchildren, occasional babysitting etc. 2. Full: High degree of contact or some responsibility for grandchildren	E13B___
CARER ROLE 0. Low/nil: No role as carer for ageing/infirm relatives 1. Partial: Some caregiving to ageing or infirm relatives but not household members. 2. Full: Substantial caregiving role e.g. household member or weekly visiting/ help and taking relative home for respite care at times.	E13C___
EXTERNAL/SOCIAL ARENA 0. Low/nil: Lack of contact with friends, acquaintances or participation in social acitivites 1. Partial: Restricted social life: some contact with friends and acquaintances. 2. Full: considerable time/effort/resources expended on social life.	E14___

ADVERSITY IN MARITAL/ PARTNER DOMAIN	RATE 0. Absent 1. Present	
INCREASE/DECREASE IN INTERACTION Include partner's absence due to working away from home or imprisonment. Take into account isolation, stigma, lack of help with children etc. Take into account the amount the partner is away and degree of contact.		E16E____
CRISIS/BREAKDOWN IN RELATIONSHIP Reflect here strain and breakdown in the relationship. Include quarrelling tension and violence. Take into account frequency, persistence and pervasiveness of negative atmosphere. Also separations and rejections.		E16F____
PARTNER'S DRINK/DRUGS/ GAMBLING/ CRIMINAL BEHAVIOUR Cover here the negative impact of such behaviour on the relationship.		E16G____
INFIDELITIES AND EXTRA-MARITAL RELATIONSHIPS Bear in mind the closeness of the relationship (e.g. whether married/ cohabiting or boyfriend), the degree of deceit involved, reaction of others etc. The extent to which S is likely to be hurt, relationship jeopardised etc.		E16H____
TENSION OR DISINTEREST IN RELATIONSHIP Rate the disinterest shown either by partner or S in the relationship and the extent to which this leads to tension and lack of interaction.		E16J____
SEXUAL PROBLEMS Rate lack of sex in a relationship where it leads to strain and conflict. Any force used by partner should be reflected. Also rate here non-health aspects of STDs.		E16L____
PARTNER'S ILL HEATH/ ACCIDENTS. Take into account partner's ill-health; consider S's nursing role; effect on his employement etc.		E16M___
DEATH OF PARTNER Take into account the aftermath of partner's death. A bereavement difficulty can be reflected for a one year period.		E16N____
DIFFICULTIES OVER LEGAL ASPECTS OF SEPARATION/DIVORCE (INCLUDING SOLICITOR CONTACT) Rate issues here to do with impending separation, or after separation in the period partner harasses her.		E16P____
SEXUAL IDENTITY DIFFICULTIES/PROMISCUITY Rate difficulties in the partner relationship(s) or with others resulting from issues such as homosexuality.Rate only if S's sexual promiscuity leads to difficulties re health or safety.		E16Q____

MARITAL/PARTNER DOMAIN

DESCRIBE CHARACTERISTICS OF MARITAL/PARTNER RELATIONSHIP DURING THIS PHASE AND OPPOSITE SEX/SEXUAL RELATIONSHIPS FOR NON-COHABITING:
(For a high peak rating the severity/threat must last at least 4 weeks)

ADVERSITY IF MARKED OR MODERATE ON

ADVERSITY TYPICAL PERIOD	ADVERSITY PEAK	LENGTH PEAK IN YEARS	DATE BEGINNING OF '2' OR ABOVE	PARTNER INVOLVED	S'S agency (If 1 or 2 on adversity	illness related (if 1/2 on adversity)
Rate: 1: marked 2: moderate 3: Some 4: little/ none	Rate: 1: marked 2: moderate 3: Some 4: little/ none	Rate: 0: < 1 year 1: 1 year 2: 2 year 3: 3 years etc..	DD MM YY	1ST E14E	-1 N/A 1. Mainly S 2. S & Other 3. S passive 4. None	-1 N/A 0. No 1. Possibly 2. Probably
E14A	PEAK 1 E14B	PEAK 1 E14C	PEAK 1 E14D	2ND E14F	E16C	E16D
				3RD E14G		

PARENTHOOD DOMAIN: CHECKLIST OF ADVERSITY

REPRODUCTION	RATE 0.Absent 1. Present
INFERTILITY: Discovering S or partner is infertile; undergoing infertility treatment; finding she can't have children for other reasons e.g. health risk.	E19E
PREGNANCY & BIRTH: unwanted pregnancies; complications and abnormalities of pregnancy. miscarriages (0-6months of pregnancy) Stillbirths (6 months of pregnancy to 1 day after birth). Induced abortions and sterilisations.	E19F
SEPARATION DUE TO ADOPTION: S's child adopted at birth; S adopts children.	E19G
S'S CHILDREN:	
CONDUCT PROBLEMS: Child's truancy, delinquency, stealing, substance abuse. Police contact for such behaviour.	E19H
SUBSTANCE ABUSE: Child's alcohol or drug use.	E19J
PSYCHIATRIC DISORDERS: Child's hyperactivity; depression, anxiety, eating disorder, self-mutiliation etc	E19K
SEXUAL BEHAVIOUR: Child's pregnancies, induced abortion etc. Underage sex, promiscuity.	E19L
ABUSE OF S'S CHILDREN Sexual or physical.	E19M
INTERACTIONS: arguments, fights, crisis in relationship breaking off contact with children; separations from children.	E19N
HEALTH: handicaps, ill-health, hospital attendances, accidents to children.	E19P
DEATH: Deaths of children (perinatal deaths 2days- 1 year) plus any later deaths.	E19Q
ADOPTEES/ SURROGATES:-Problems because S not natural parent. Problems re S's child learning of own adoption.	E19R
OTHER:	

PARENTHOOD DOMAIN

DESCRIBE CHARACTERISTICS OF PARENTHOOD DURING THIS PHASE
Rate -1 on all scales if S does not have children unless (i) there is a difficulty associated with not being able to conceive. Include step or adoptive children.

ADVERSITY TYPICAL PERIOD	ADVERSITY PEAK	LENGTH PEAK IN YEARS	DATE BEGINNING OF '2' OR ABOVE	CHILD INVOLVED id number	AGENCY (If 1 or 2 on adversity)	ILLNESS RELATED (If 1/2 on adversity)
Rate: 1: marked 2: moderate 3: Some 4: little/ none	Rate: 1: marked 2: moderate 3: Some 4: little/ none	Rate: 0: < 1 year 1: 1 year 2: 2 year 3: 3 years etc..	DD MM YY	1ST E18E	-1 N/A 1. Mainly S 2. S & Other 3. S passive 4. None	-1 N/A 0. No 1. Possibly 2. Probably
E17A	PEAK 1 E17B	PEAK 1 E17C	PEAK 1 E17D	2ND E18F	E19C	E19D
				3RD E18G		

MATERIAL DOMAIN: CHECKLIST OF ADVERSITY

EDUCATION	
S's Education: dyslexia, illiteracy, inability to spell or write English.	E22E
S failing exams; failing at job interviewsZ	E22F
Other education difficulties of subject.	E22G
WORK	
DIFFICULTY FINDING WORK/ TIME OFF. S's unemployment, difficulty finding work retirement. Sick leave, time off work, strikes.	E22H
DIFFICULT WORK CONDITIONS S's long hours, strain. Working at below trained level etc. Lack of time off, low pay	E22J
NEGATIVE WORK RELATIONSHIPS. problems over promotions, sexual harrasment at work, negative interactions, work gossip, office politics etc.	E21K
LEGAL DIFFFICULTIES RE WORK	E22L
Other	E22M
HOUSING	
HOMELESSNESS	E22N
EVICTION Threat of eviction, non-payment of rent,	E22P
POOR HOUSING CONDITIONS Overcrowding, lack of privacy, lack of amenities	E22Q
NEIGHBOUR DIFFICULTIES	E22R
LEGAL DIFFICULTIES RE HOUSING	E22S
FINANCE	
FINANCIAL PROBLEMS Debts, poverty, loan sharks, borrowing off close others	E22T
POSSESSIONS Burglaries, thefts, loss of valuable possessions	E22U
LEGAL DIFFICULTIES INVOLVING POSSESSIONS Social security frauds	E22V
Other	E22M

MATERIAL DOMAIN

Include education, work, and finance issues.

ADVERSITY TYPICAL PERIOD	ADVERSITY PEAK	LENGTH PEAK IN YEARS	DATE BEGINNING OF '2' OR ABOVE	SUBCATEGS OF ADVERSITY	AGENCY (If 1 or 2 on adversity)	ILLNESS-RELATED (If 1/2 on adversity)
Rate: 1: marked 2: moderate 3: Some 4: little/ none	Rate: 1: marked 2: moderate 3: Some 4: little/ none	Rate: 0: < 1 year 1: 1 year 2: 2 year 3: 3 years etc..	DD MM YY	Rate - adverst y 0. LOW (3-4 1. HIGH(1-2) EDUCATION E21E	-1 N/A 1. Mainly S 2. S&Other 3. S passive 4. None	-1 N/A 0. No 1. Possibly 2. Probably
E20A	E20B	PEAK 1 E20C	PEAK 1 E20D	WORK E21F	E22C	E22D
				FINANCE E21H		

SOCIAL DOMAIN: CHECKLIST OF ADVERSITY

FAMILY OF ORIGIN	RATE - 0. Absent 1. Present
INCREASE/ DECREASE IN INTERACTION Difficulties associated with lack of contact; too much contact with family.	E25E
CRISIS BREAKDOWN IN RELATIONSHIP: Arguments & rows, breaking off contact	E25F
FAMILY MEMBERS ANTISOCIAL BEHAVIOUR: Extent to which family members criminal behaviour impinges on S.	E25G
FAMILY MEMBERS PSYCHIATRIC HEALTH/ SUBSTANCE ABUSE:TAke into account extent to which this impinges on S.	E25H
FAMILY MEMBERS ILL-HEALTH/ ACCIDENTS: Take into account the extent to which these impinge on S, or are life-threatening, stigmatising e.g. AIDS etc.	E25J
DEATH OF FAMILY MEMBERS :Problems associated with deaths of family members	E25K
LEGAL DIFFICULTIES INVOLVING FAMILY: Inheritance disputes	E25L
EXTERNAL ARENA	
INCREASE/ DECREASE IN INTERACTION: Breaking off contacts with friends/ support figures.	E26M
CRISIS BREAKDOWN IN RELATIONSHIP: Arguments & rows, betrayals, revelations etc.	E26N
PSYCHIATRIC OR PHYSICAL HEALTH OF OTHER: Only include if impinges on S	E26P
DEATH OF CLOSE FRIEND	E26Q
PROBLEMS WITH LODGERS/ FLAT SHARE: Negative interaction, lack of privacy etc.	E26R
INTERACTIONS RE EXTERNAL ARENA: Rows and arguments at social clubs, evening classes etc.	E26S
OTHER	E26T
EX-PARTNERS	
HARRASSMENT & VIOLENCE Harrassment by ex-parter; violence; rape; jealousy over S's boyfriends/ partners	E26U
LEGAL ASPECTS Legal problems e.g. custody & child care disputes; maintenance disputes	E26V
DISPUTES OVER CHILDREN Ex-partner turning children against her, manipulating children etc. Abusing children	E26W

SOCIAL DOMAIN

Include any crises affecting (i) parents, siblings, surrogate parents or surrogate siblings. Rate whether or not S is living in parental home (ii) External arena (friends, ex-partners, support figures)

ADVERSITY TYPICAL PERIOD	ADVERSITY PEAK	LENGTH PEAK IN YEARS	DATE BEGINNING OF '2' OR ABOVE	SUBCATGORY	ID OF OTHER	S's AGENCY (If 1 or on adversity)	ILLNESS RELATED (If 1/2 on adversity)
Rate: 1: marked 2:moderte 3:Some 4:little/-no	Rate: 1: marked 2: moderte 3: Some 4:little/ no	Rate: 0: < 1 yr 1: 1 year 2: 2 year 3: 3 yers etc..	DD MM YY	Rate adversty 0.LOW(3-4) 1.HIGH (1-2 FAMILY E23E	1ST E23H	-1 N/A 1.Mainly S 2. S & Other 3: S passive 4. None	-1 N/A 0. No 1.Possibly 2.Probably
E23A	PEAK 1 E23B	PEAK 1 E23C	PEAK 1 E23D	SOCIAL E23F	2ND E23J	E25C	E25D
				EX-PARTNER E23G	3RD E23K		

MISCELLANEOUS DOMAIN: CHECKLIST OF ADVERSITY

S'S HEALTH DIFFICULTIES RATED: Absent 1. Present	
Serious (life threatening) illness: cancer, heart disease, etc	E2SXA
Long-term health difficulties (non-life threatening) diabetes, rheumatism	E2SXB
Health consequences of sexual behaviour/ drug use/ alcohol	E2SXC
Hospital stays, operations	E2SXD
Stays in psychiatric hospital; being sectioned.	E2SXE
Handicaps: blindness, deafness	E2SXF
Personal appearance: obesity, handicap, disfigurement.	E2SXG
CRIME/ LEGAL (focused on S)	
S's police contact (e.g. theft, drug dealing etc)	E2SXH
Problems arising from drug use: negative interaction with drug dealers, conflicts about reporting to police etc.	E2SXJ
Harrassment: anonymous telephone calls, letters.	E2SXK
Attacks from strangers: mugging, rape.	E2SXL
Racial/ sexual harrassment.	E2SXM
OTHER DIFFICULTIES (focused on S)	
Geopolitical difficulties: war, deportation.	E2SXN
Involvement in disasters e.g. floods, ships sinking, earthquakes, explosions	E2SXP
Other	E2SXQ

MISCELLANEOUS DOMAIN

ADVERSITY TYPICAL PERIOD	ADVERSITY PEAK	LENGTH PEAK IN YEARS	DATE BEGINNING OF '2' OR ABOVE	SUBCATEGORY OF ADVERSITY	AGENCY (If 1 or 2 on adversity)	ILLNESS-RELATED (If 1/2 on dversity)
Rate: 1: marked 2: moderate 3: Some 4: little/ none	Rate: 1: marked 2: moderate 3: Some 4: little/ none	Rate: 0: < 1 year 1: 1 year 2: 2 year 3: 3 years etc..	DD MM YY	0 = - LOW (3/4) 1 = HIGH (1/2) HEALTH E25WE	-1 N/A 1. Mainly S 2. S & Other 3. S passive 4. None	-1 N/A 0. No 1. Possibly 2. Probably
E25WA	PEAK 1 E25WB	PEAK 1 E25WC	PEAK 1 E25WD	CRIME E25WF	E25WP	E25WQ
				GEO-POL E25WG		

CHANGE POINT (TRANSITION TO NEXT PHASE)

Rate the following scales -1:N/A if current phase. Consider the weeks/months around the change point i.e. end of phase and beginning of new phase. Do not rate a period of over 6 months to cover exit and entrance.

Describe circumstances of change point.

REASON FOR EXIT FROM PHASE

0.Education e.g. leaving home to go to university; failing training course having to leave college/university.

1. Work e.g changing career, being relocated some distance away, retirement.

2.Reproduction e.g. birth of child leads to change in housing.

3.Housing e.g. eviction forced to move some distance away, getting own flat after leaving parental home; buying new house some distance away.

4.Money/ possessions: inheriting money leading to change in lifestyle. Having to leave to escape debt/ debt collectors.

5.Crime/ legal: on the run to avoid police, harrassing partner. Financial compensation results in change to life style.

6.Health/ treatment/ accidents: retirement through health reasons, physical disability/ illness changes lifestyle.

7.Marital/partner relationship:e.g. separation from partner; moving in with new partner.

8.Other relationships: e.g. leaving home because of difficulties with parents or flat mate. Parents invite her back home to live.

9.Children: e.g. move to be nearer adult children, last child leaves home.

10.Deaths: death of partner or parents involving life changes.

11.Miscellaneous

MAIN REASON FOR EXIT E28A_____

SUBSIDIARY REASON FOR EXIT E28B_____

Adversity associated with EXIT SITUATION Crises and threatening nature of reasons for exiting from phase. Take into account rejections, prior difficulties etc., what S is leaving/losing etc.

1. Marked
2. moderate
3. Some
4. Little/none

Describe:

ADVERSITY OF EXIT E28AC____

POSITIVE ASPECTS OF EXIT

Reflect any positive aspects of leaving prior situation in terms of likely relief of leaving behind difficulty circumstances etc.

1. Marked
2. moderate
3. Some
4. Little/none

Describe:

POSITIVE ASPECTS OF CHANGE E28C____

Does change represent a likely fresh start?

A fresh start is a change from a period of adversity or deprivation (in any arena) to one which involves an improvement in conditions, lifting of a burden together with the creation of new positive role/ relationship/ housing/ etc.

Take the vantage point of the time of change (maximum of 6 months)

0. No
1. Delogjamming: difficulties have cleared but no new role/relationship; e.g. separation/divorce
2. Potential fresh start: the beginning for new role/relationship but not yet clear if permanent e.g. meets new boy-friend or girl-friend
3. Fresh start: period of difficulty over and new role/relationship etc more definite e.g. gets married

E28D____

Problems, sources of undependability or unpredictability known by S at the time relating to the next phase being embarked on. Rate those negatives that seem apparent at the point of change even if these don't actually materialise.

1. Marked
2. moderate
3. Some
4. Little/none

Describe:

ADVERSITY OF ENTRANCE E29_____

S'S ACTIVE AGENCY OVER CHANGE

Rate the extent to which S is an active agent in initiating clnage.

1.S is the main agent.

2.S is equal to other agents.

3.S has a passive/compliant role. (Other is main agent, S is acquiescent).

4. S has little or no agency

E30B_____

PREVIOUS PARTNER RECORD

H Record CHARACTERISTICS OF PARTNERSHIP

Phases No. (if more than one give first) ☐

ID _____

Rater _____

Rate one record for the first dating/romatic relationship that S felt 'serious' about. Then rate a separate record for all cohabitees/marriage partners and fathers of S's children. If S has none of these relationships then rate for the boyfriend with whom she had the longest relationship. If there is a major qualitative change in the nature of the relationship then record on an HC - Changes record

CIRCUMSTANCES ASSOCIATED WITH MEETING PARTNER

Describe how S met partner in full
Include place of meeting, who introduced them, number of meetings prior to start of relationships.

See back page for any continuation

Partner identifier
(Unique identifying number) H1 _____

Date of start of relationship H2 _____ DD MM YY

Date at start of cohabitation H3 _____ DD MM YY

Date of marriage H4 _____ DD MM YY

Date of end of relationship
-1 if still continuing H5 _____ DD MM YY

Partner's Hope-Goldthorpe usual rating during cohabiting relationship
(Predominant) (36 points)
37-unemployed

Occupation_____ H6 _____

Partner's Hope-Goldthorpe rating at time of meeting
(36 points)
37= unemployed

Occupation_____ H6A _____

Number of partners previous marriages/cohabitations H6B _____

Number of widowings H6C _____

Partner's children by other women/men H6D _____
0.None.
1.One in cohabiting/marital relationship.
2.More than one in cohabiting/marital relationship.
3.One out of marital/cohabiting relationship.
4.More than one out of marital/cohabiting relationship.
4.Some in and some out of marital/cohabiting relationship.

Partner's cultural background H6E _____
0.White indigenous (eg. U.K.).
1.White indigenous culture - other countries (eg.Australia, Republic of Ireland).
2.White non indigenous (eg.Italy).
3.Black, U.K.born.
4.Asian, U.K.born.
5.Mixed U.K.born (eg.one Black or Asian parent and one other).
6.Black, West Indian.
7.Black African.
8.Asian (eg.Indian, Pakistani, Sri Lankan).
9.S.E.Asian (eg. Chinese, Vietnamese).
10.Other.

Degree of similarity in S and partner's background and experience

Rate the degree to which S and her partner had similiar backgrounds and experiences at the time of meeting. Take into account family culture, cultural factors, religion, social class, childhood experience of neglect/ loss of parent etc.

1.Highly similar
2.Moderately similar
3.Somewhat similar
4.Little/no similarity

HSL _____

Describe here any areas of actual or potential conflict in S and her partner's cultural/religious background

Degree to which negative factors associated with partner were apparent in first six months of cohabitation

Rate the degree to which negative factors were apparent in the first months of cohabitation, ie partner carried a knife, got into fights, was aggressive, had been in prison, etc.

1.Marked - negative factors clearly present
2.Moderate - negative factors suggested
3.Some - some indication of negatrive factors present
4.Little/none - no negative factors, or none evident at this stage

Describe:

NEGATIVE FACTORS APPARENT H6M _____

PARTNER HISTORY OF UNDEPENDABILITY - PRIOR TO RELATIONSHIP WITH S

Rate the following scales for S's partner's behaviour prior to their relationship.

Partner ever convicted/imprisoned/borstal H7 _____
0.No.
1.Yes - convicted but non custodial sentence.
2.Yes - borstal only.
3.Yes - prison.

Partner's psychiatric history H8 _____
0.No.
1.Yes - GP only.
2.Yes - Out-patient.
3.Yes - In-patient.
4.Yes but never treated.

Partner ever had drug or alcohol problems prior to relationship with S H9 _____
0.No.
1.Possible - but never treated.
2.Probable - but never treated.
3.Possible - treated.
4.Probable - treated.

QUALITY OF RELATIONSHIP WITH PARTNER AT START OF RELATIONSHIP

Reflect changes in quality on an HC-Change record.

Overall quality of relationship

Rate the quality of the relationship, taking into account affection, confiding, dependability negative interaction and conflict in terms of the types below.
(d= discord, a=apathy/lack of affection)

1. Good.

2. Good/average (d) - some tension.
3. Good/average (a) - less affection.

4. Poor/ average (d)- some disharmony.
5. Poor/ average(a) - some indifference.

6. Poor (d) - constant quarrelling.
7. Poor (a)- apathy and avoidance.

Describe relationship:

OVERALL QUALITY OF RELATIONSHIP WITH PARTNER H10 _____

Responsibility for circumstances leading to separation

The scale takes into account the build up to the separation and any marital difficulty preceding it. Thus the partner who has an extra-marital affair, who has been violent and undependable would probably be the one represented on the scale. Where the break-up is due to general incompatibility with attendant tension or quarrels, both partners are considered responsible i.e. '2 - joint'.

1. Subject responsible
2. Joint: more or less equally responsible
3. Partner responsible
4. Neither really responsible
5. Unclear about responsibility

RESPONSIBILITY FOR CIRCUMSTANCES LEADING TO SEPARATION H11 _____

Initiating the separation

This scale deals with behaviour immediately before the separation, and reflects who took the initiative in suggesting the separation (and, where applicable, carrying it through).

1. Subject's initiative
2. Subject's initiative, but provoked
3. Joint initiative
4. Partner's initiative, but provoked
5. Partner's initiative
6. Unclear

INITIATION OF SEPARATION H12 _____

PARTNER'S ANTISOCIAL BEHAVIOUR

A pervasive pattern of disregard for and violation of rights of others occurring since age 15 years, as indicated by three (or more) of the following (A1 to A7), plus B and C:

RATE: 0:ABSENT, 1:MILD (not severe/frequent), 2:MARKED

	INDICATORS OF ANTISOCIAL BEHAVIOUR	RATING
A1.	Failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest.	H14
A2.	Irritability and aggression as indicated by repeated physical fights or assaults.	H15
A3.	Impulsiveness or failure to plan ahead	H17
A4.	Deceitfulness as indicated by repeated lying, use of aliases, conning others for personal profit or pleasure.	H18
A5.	Reckless disregard for safety of self or others.	H19
A6.	Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.	H22
A7.	Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations.	H22A
	OTHER CRITERIA:	0:ABSENT 1:PRESENT
B.	The individual is at least 18 years of age.	H22B
C.	There is evidence of Conduct Disorder with onset before age 15 years.	H22C

ANTISOCIAL PERSONALITY PRESENT? 0:ABSENT 1:POSSIBLE 2:PROBABLE H23 _____

HC RECORD CHANGES IN QUALITY OF MARRIAGE/PARTNERSHIP 20

ID _____

SISTER _____

RATER _____

HC1 Date of change		HC2 New rating e.g. 4 (Poor/average)	HC3 Partner identifier	HC4
	H_____			
DD MM YY				
	H_____			
DD MM YY				
	H_____			
DD MM YY				
	H_____			
DD MM YY				
	H_____			
DD MM YY				
	H_____			
DD MM YY				
	H_____			
DD MM YY				
	H_____			
DD MM YY				

APPENDIX 4.12. ABRIDGED INTERIVEW PROTOCOL: THE INTEGRATION OF THE APFA AND ALPHI MEASURES, AND THE PERSONALITY DIAGNOSITC INTERVIEW

The following protocol is an attempt to merger the ALPHI and APFA measures. Familiarity with both interview schedules in their original format and their rating criteria is, obviously, essential in order to carry out the interview in such a way that all necessary information is obtained.

The ALPHI divides adult life into phases starting from age 17. Phases are determined by changes in partners, work, geographic moves, etc. In contrast, the APFA rates adult life in two time bands, 21-30 and the last five years. The interviewer must keep in mind both ALPHI phase criteria and APFA time bands while interviewing, and it helps to have a paper and pencil handy to jot down information, dates, etc., during the course of the interview. Periods which cannot be rated fro the APFA due to psychiatric illness of an incapacitating nature must be kept in mind when interviewing since the interviewer may be required to lengthen the baseline period including data from before age 21 or beyond age 30. This information will have been obtained from the SADS-L.

The ALPHI is primarily interested in crises or adversity and subsequent coping. The APFA looks at functioning in different domains. The interviewer needs to be aware of these different foci throughout the interview.

Other interviews used previously in the study will give the interviewer some background data regarding the subjects' adult life history (i.e., Launching questions, TAPI) and may already cue the interviewer in to important changes which will help delineate phases. There are different ways to determine phases. The interviewer may ask the subject to outline what they would see as the different phases of their life (this can be done with the tape recorder off). One can try to elicit a brief outline of their life history according to work, partner and geographic moves. Each interview will different and this it is important to be flexible about the order in which different domains are asked about, depending on the subject's history.

Several domains are included in the protocol. Most are relevant to both ALPHI and APFA measures; some are relevant only to one measure. Some domains are asked about in greater detail than others. Domains include: Education/Work, Finances, Marital/Intimate Relationships, Family of Origin, Friendships, Non-Specific Social Contacts, Ex-Partners, Children, Antisocial Behavior, Negotiations, Coping and Independence, and Miscellaneous.

Rather than ask about each domain in detail, per phase or time band, it is more natural to help the subject chronologically 'tell their life story'. The narrative seems to flow more easily. However, this does require that the interviewer makes sure to date significant changes as the interview unrolls, so that events can be rated later on according to the appropriate phase/time band. Depending on what domain seems to be most significant in defining phases (i.e., partners, career development, etc.); the interviewer can guide the subject to first tell his/her work history or relationship history.

For ALPHI purposes, it is necessary to elucidate the reason for each phase change (this is usually evident from the narrative) and whether there were problems associated with the change.

Again, the order in which the domains are asked is not rigid and binding and the interviewer, once comfortable with the measure, should feel free to move back and forth within the protocol.

Following several domains (i.e., family, partners, work, friendship), the relevant PDI questions that ask subjects to describe two vignettes are asked. These questions appear at the end of the merged ALPHI/APFA protocol. Alternatively, one can ask for the vignettes and the additional PDI questions en masse at the end of the protocol. PDI questions that are not asked during the merged ALPHI/APFA protocol need to be asked at the end of the interview.

TRANSITIONS, PLANNING AND COPING INTERVIEW (LORNA CHAMPION)
REVISED EDITION (INCLUDING ALPHI QUESTIONS, PHASE DELINEATION)

MARCH 1996

TRANSITIONS/PLANNING/COPING/CALENDAR OF TRANSITIONS

Note: The Transitions/Planning/Coping questions (Lorna Champion) are integrated below with the mini-launching questions, and are used as a way to map out ALPHI life phases before beginning the ALPHI.

LEAVING HOME DATE

I'd like to ask you a bit about your adult life - from when you left home.

How old were you when you left home?

Can you tell me how you came to leave home, what happened?

Did things at home influence you in leaving?

What was your relationship with your family like when you left home?

Note: Explain to subject that in order to talk about their adult life since leaving home or age 17 (whichever came first), we are going to try and divide adulthood into fairly large blocks of time ("phases"), according to where they lived, partners, work/study and any other significant changes that may have taken place. The following questions will 'walk them through' their adult life in a more general way. Later, (in the ALPHI-APFA merge interview) we will ask more specific questions about different domains in each phase of their adult life.

TRANSITIONS/PLANNING/COPING OVERVIEW

Introduction

Now I would like to ask you about some of the ideas you may have had about what you wanted to do since you left school. I am particularly interested in what you hoped for when you left school and what you hope for now.

Note: Aspects of the transitions will probably have cropped up during the LEDS. Try to remember this information and use it as a way in to assessing plans especially for determining any major change points at which opportunities were opened up or closed down.

HOMES/

MOVES

When you first left home where did you live?

How long were you there?

How did you come to be there?

What type of housing did you live in?

Did you live alone or with others?

Where did you live next, for how long, with whom?

(Note: Establish approximate dates [age] of all moves to enable phase divisions).

Transitions - INDEPENDENT LIVING

Can you tell me how old you were when you first began to contribute to household expenses?

Note stage reached on coding sheet - ask about each transition as appropriate.

If still in parents home - ask if ever lived away for a year or more?

Have you ever lived away from your family so that it would take at least a whole day to visit?

If more than once, note age at first time and most recent.

Have you ever lived in property which was registered in your name?

Have you ever had a mortgage?

How do you feel about where you live at present?

Do you have any plans/ideas about where you you would like to live in the next 5-10 years? (Or in what type of housing?)

How possible do you think it will be for this to happen?

Have you ever lived anywhere that you found just right for you at the time?

Do you think you are the kind of person who cares very much about the place you live in or doesn't it bother you really?

If appropriate ask: How would you feel if you had to stay in the housing/place you are in now for the next 5 years?

Ask as appropriate: Have you ever been the only or main provider for someone else? Eg, a child, a sick parent, or spouse?

Note age when this first occurred and for how long and most recent situation if different from first.

Independent Living Transitions Coding Sheet

Summary of Transitions

	Age	Planned	Readiness	Desirability
First regular contribution to household				
Leaving parental home not financially independent				
Leaving parental home financially independent				
Living in property registered in own name				
Moving away from area				
Providing for other as sole or main provider - first				
Providing for other as sole or main provider - most recent				

Plans - re independent living - note future plans as well as any past plans.

WORK/ STUDY

I'd like to ask you now about your work/studies.

Are you currently working, studying, unemployed?

Is/was this the sort of job/study you wanted when you were at school?

Did you ever think about what job you would do when you left school while you where still at school? Did you have any ideas or make any plans?

What happened ?

If no:-

Did you have any idea what you wanted to do when you left school?

If no:-

Did you decide what you wanted to do later on?

If no:-

Have you ever had a job or done a course you liked reasonably well that made you feel you wanted to do more of that type of thing?

-Can you tell me more about it?

-How did you get into it (own idea, others idea?)?

-What happened?

If no:-

Did you have any ideas of what you might like to do in an ideal world - if things were exactly as you hoped or dreamed they would be?

Note

Age plan began
Dte plan abandoned
Practical steps taken
Acknowledgement of idea to other
Successes and rewarding experiences
Setbacks
Plan devised by other person
Perceived adequacy of support

Employment/Education Transition - Plans

Plans/ideas on leaving school Yes/No

Specify

Intermediate Plans

Current and future plans - note current investment/commitment/satisfaction
Include satisfaction with current job.

EDUCATION and Educational Transitions

If the subject has done any educational courses since leaving school ask about each course. Include how they got interested in it - own idea/others idea, etc..

Obtain information on educational transitions.

Ask:- Were there any problems in completing the course?

- Any setbacks due to financial difficulties failing exams, periods of wanting to give up or actually giving up?

- Any years repeated?

- Any more courses later on?

If S abandoned a course make sure you ask what they did next,
Eg - Did you have another idea about what to do next?
- How did that turn out?

Education Transitions Coding Sheet

Summary of Transitions

	Age	Planned	Readiness	Desirability
Began course at school				
Left school				
Began course - first				
Began course - most recent				
Completed course - first				
Completed course - most recent				

Employment and Employment Transitions

Can you tell me about the main changes in what you hoped for work-wise up until now?

Check main job changes and S's perception of these.

Ask about promotions and if there was responsibility for others at each stage.

If S describes any major setbacks (eg where an important plan went wrong).

Ask:- Did anyone help you at this time?

- Did you feel people helped you enough?

- Was there anyone who could have helped you more?

Note: Make sure to have a clear outline (in terms of approximate dates) of all significant job changes in order to help map out ALPHI phases.

Employment Transitions Coding Sheet

Summary of Transitions

	Age	Planned	Readiness	Desirability
First job				
Better job				
Promotion - first				
Promotion - most recent				
Responsible for others - first				
Responsible for others - most recent				
Major change in work				

For women or those with other dependents

Maternity leave - first				
Maternity leave - most recent				
Gave up work due to children - first				
Gave up work due to children - most recent				
Returned to work - first				
Returned to work - most recent				

TRANSITIONS - PERSONAL RELATIONSHIPS

When you left school do you remember if you had any idea how you hoped things would work out relationships-wise?

To give you an idea of what I mean:

Were you keen on having a serious sexual relationship (boys/girls) then or weren't you interested?

(Be alert for homosexuality.)

If not interested ask: Have you become more interested since?

Did you know if you wanted to get married?

What did you think about marriage generally then?

-Did you feel generally positive or negative about it?

If S gives a definate answer ask: Do you know why you felt that way?

Have your attitudes changed since then?

-If yes, when did it change (ie their age)?

-Where there any events or incidents that brought about this change?

<u>For those who are not married and cohabiting or in a steady relationship.</u>

Do you ever wish things were different to the way they are now? For example, do you ever wish it was easier to meet people (men/women) who you found attractive, or do you ever wish it was easier to make relationships last once they get started?

If S answers yes ask if anything had happened to leave them feeling this way, for example an upsetting experience with someone or a relationship which had gone wrong in the past?

Personal Relationships Transitions Coding Sheet

Plans/Ideas on Leaving School

Keen on marriage
children
staying single

Intermediate

Note changes of attitude - reasons.

Current and Future Plans

Not current investment/commitment/satisfaction.

Note

gae plan began
Date plan abandoned
Practical steps taken
Acknowledgement of idea to other
Successes and rewarding experiences
Setbacks
Plan devised by other person
Perceived adequacy of support

Note: Interviewer will know from the CECA who first serious boyfriend was and will know current partner (if relevant) from demographic questions. After asking the questions below about the current partner, the interviewer needs to establish all other partners, length of relationship, and whether it was a cohabiting one for both ALPHI and APFA purposes.

Ask about each transition listed on opposite page where appropriate.

Was getting married/deciding to live together something you planned well in advance or did it just happen spontaneously?

Can you tell me how long you had known ——— before you decided to get married/live together?

-How long was it before this actually happened?

-Did it go according to plan? Or as you hoped it would?

-Were there any problems?

Probe for delaying tactics on either side, parental disapproval, financial worries, housing problems, etc., getting pregnant?

Note: Make sure to map out all other relationships (particularly those lasting more than 6 months and/or were cohabiting), with rough dates for beginnings and endings of relationships.

CHILDREN

Note: Get details of all subject's children, their dates of birth, their respective fathers. Begin with pregnancy history (see pages 15 - 17).

Personal Relationships Transitions Coding Sheet

Summary of Transitions

	Age	Planned	Readiness	Desirability
(First sexual relationship)				
Cohab - first				
Cohab - most recent				
Engagement				
Marriage - first				
Marriage - most recent				
Divorce				
Pregnancy - first				
Pregnancy - most recent				
Births				
First child starts school				
Child-starts-school - most recent				
Loss of main responsibility for child following divorce				

PREGNANCY HISTORY

IF RELEVANT:

Now, I'd like to ask a bit about your pregnancies

OR:

Have you ever been pregnant?

IF NOT ALREADY ASCERTAINED:

How many pregnancies have you had?
Have any ended in miscarriage or stillbirth?
Any terminations?

Were your pregnancies planned?

IF NOT:

What happened, did you you use contraception?
Why not?

Have any of your pregnancies been in difficult circumstances?
Were any of them when you weren't living with the father of the child?

Were any of them in difficult financial or housing situations?
Any in a bad relationship?

What about any problems after the child was born?

(PROBE ABOUT THE FOLLOWING POSSIBLE CRISES:)

REPRODUCTION

INFERTILITY: Discovering S or partner is infertile; undergoing infertility treatment; finding she can't have children for other reasons e.g. health risk.
PREGNANCY & BIRTH: unwanted pregnancies; complications and abnormalities of pregnancy. miscarriages (0-6months of pregnancy) Stillbirths (6 months of pregnancy to 1 day after birth). Induced abortions and sterilisations.
SEPARATION DUE TO ADOPTION: S's child adopted at birth; S adopts children.

IF ANY OF THE ABOVE THEN ASK THE FOLLOWING FOR EACH 'SEVERE' PREGNANCY OR BIRTH

So how old were you then ?

Did you plan to get pregnant ?
Did you make a decision to get pregnant?

Were you using any contraception at the time ?
IF YES:
What were you using?

(e.g. pill, diaphragm,sheath)
What went wrong?

IF NOT:
Why not?
Did you know about contraception?
Were you too shy to ask?

IF RELEVANT:
Did you consider terminating the pregnancy?
Were there any difficulties associated with it?

FEELINGS

How did you feel about the pregnancy?
Did those feelings change during the pregnancy?
What about after the birth?

SUPPORT FROM PARTNER

IF NOT ESTABLISHED:

Who was the child's father?
ALL:
How did... (your partner) react to the pregnancy?
Was he pleased?
Annoyed? Worried? Disinterested?

Did it affect your relationship?
In what way?

Was he very supportive?
In what way?

What about after the baby was born?
Did he do much to help?
What?

Did you ask for much help from him?
During the pregnancy?
What about after the baby was born?

IF RELEVANT:

How much contact did you have with him after?

OTHER SUPPORT

Was there anyone who was helpful at that time?
Who?
Were they sympathetic?

Did they offer practical help?
What?

Was there anyone who was particularly unhelpful?
Who?
What did they say or do?

Did you tell your mother or father about the pregnancy straight away?

IF NO:
Why not?

IF YES:
Were they helpful?
In what way?
Did they change after the baby was born?

Did you ask them for help?

What about your brothers and sisters - did you tell them?

IF NO:
Why not?

IF YES:
Were they very helpful?

Can you tell me what area of your life has given you most pleasure in the last year?

WORK FAMILY OTHER INTERESTS

If S is unmarried and has no children ask about social life instead of family

Is the last year fairly typical of the last 5 or so?

If no: What do you think you would have said was typical overall - ask them to repeat the percentages.

Can you tell me what area of your life has taken most of your time and energy in the last year?

WORK FAMILY OTHER INTERESTS

If S is unmarried and has no children ask about social life instead of family

Is the last year fairly typical of the last 5 or so?

If no: What do you think you would have said was typical overall - ask them to repeat the percentages.

THE ANNA FREUD CENTRE

LONG-TERM FOLLOW -UP STUDY

APRIL 1996

REVISED ALPHI-APFA INTERVIEW PROTOCOL

J. Marital/Partner History

Note: Starting at age 17, determine whether subject had a boyfriend/sexual partner or was married/cohabiting for each phase. If subject was not married/cohabiting during the phase being talked about, ask the questions under A; if cohabiting, ask the questions under B. Make sure to get specific information about the last five years, asking questions in the present tense. If there is a pattern of brief cohabitations (more than 3, lasting < 6 months), it is not necessary to establish the exact number. Similarly, one need only establish the predominant pattern of quality of relationship; details of each are not required.

A. NOT MARRIED OR COHABITING:

Did you have more girl/boyfriends at that time?

IF NO, OR ONLY A FEW RELATIONSHIPS OF SHORT DURATION, OR LOW INTIMACY:

Did you want to have more girl/boyfriends?

Did you meet girls/boys and go out with them?

Did you ever go out with a girl/boy hoping it would develop into a serious relationship?

What seemed to go wrong?

IF YES:

How many were there? Can you tell me about them?

Did you become close to (any of) your boy/girlfriend(s)?

Which one was the longest relationship? How long did that last?

What sorts of things did you do together? Did you confide in X?

ADVERSITY Were there any problems associated with the relationship(s)?

What?

Probe about the following possible crises:

[Interviewer can say, "I'll run through a list of possible problems. Tell me if any of these things have happened to you. If not relevant, we'll move on"]

INCREASE/DECREASE IN INTERACTION Irregular contact with boyfriends; unreliability about arrangements. Frequent splitting up, change of partner.

CRISIS/BREAKDOWN IN RELATIONSHIP Reflect here strain and breakdown in the relationship. Include quarreling, tension, and violence. Take into account frequency, persistence and pervasiveness of negative atmosphere. Also separations and rejections.

PARTNER'S DRINK/DRUGS/GAMBLING/CRIMINAL BEHAVIOR Cover here the negative impact of such behavior on the relationship.

INFIDELITIES AND EXTRA-MARITAL RELATIONSHIPS Bear in mind the closeness of the relationship (e.g., whether married/cohabiting or boyfriend), the degree of deceit involved, reaction of others, etc. The extent to which S is likely to be hurt, relationship jeopardized, etc.

TENSION OR DISINTEREST IN RELATIONSHIP Rate the disinterest shown either by partner or S in the relationship and the extent to which this leads to tension and lack of interaction.

SEXUAL PROBLEMS Rate lack of sex in a relationship where it leads to strain and conflict. Any force used by partner should be reflected. Also rate here non-health aspects of STDs.

PARTNER'S ILL HEALTH/ACCIDENTS Take into account partner's ill-health; consider S's nursing role; effect on his employment, etc.

DEATH OF PARTNER Take into account the aftermath of partner's death. A bereavement difficulty can be reflected for a one year period.

DIFFICULTIES OVER LEGAL ASPECTS OF SEPARATION/DIVORCE (INCLUDING SOLICITOR] CONTRACT) FROM OTHER PARTNERS Rate issues here to do with impending separation, or after separation in the period partner harasses her.

SEXUAL IDENTITY DIFFICULTIES Rate difficulties in the partner relationship(s) or with others resulting from issues such as homosexuality.

PROMISCUOUS SEXUAL BEHAVIOR DIFFICULTIES Rate only if S's sexual promiscuity leads to dangerous behavior.

B. MARRIED/COHABITING:

Now I'd like to ask you a few general questions about X.

HISTORY OF RELATIONSHIP

When did you meet X?

How old were you then?

How old was s/he?

Was s/he involved with anyone else when you met him/her?

IF YES:

How long did that go on for?

Had s/he ever been married before?

Did s/he have children?

How long had you been going out with him/her before you started living together/got married? How old were you? How old was your partner?

IF RELEVANT:

How long were you together?

SIMILAR BACKGROUND

Do you feel you came from similar backgrounds or not?

Were there any important differences?

Do you think there was anything about his/her background that affected his/her relationship with you?

NEGATIVE FIRST MONTHS

Were there any problems in the relationship in the first few months after you met him/her?

IF YES: What?

QUALITY OF RELATIONSHIP

RELATIONSHIP QUALITY

In general, how did you get on with your partner? Did you feel close to him/her when you first lived together?

Did that change? When?

Were there things that you positively enjoyed doing together?

Did you have a lot of interest in common, such as going out to the cinema, or to visit family or friends?

What about at home?

How often did you do that?

CONFIDING

Did you talk about important or personal things together?

Like worries over the children? With relatives? Health problems?

Could you confide easily or with difficulty? Even about your most personal feelings?

If you tried to talk to him/her about something, how would s/he react?

Did s/he keep the things you did tell him/her about to him/herself?

Or has s/he ever repeated it to someone else?

Have you ever regretted anything you did tell him/her?

Why? What was that? When did you feel that?

Was your partner reliable?

Did s/he come and go at a regular time so that you knew when to expect him/her in?

PROBE: Did s/he ever come in early/late?

How did you feel about this?

Did s/he ever go out on his/her own?

In the evening or at the weekend?

IF YES: Did you know where s/he went?

Did you mind?

Did you depend on your ex-partner?

Was that for practical things, e.g., financial?

What about emotionally?

Did the relationship weather many problems?

Did it make the relationship stronger at any time?

SUPPORT Did s/he ever support you at a time of crisis or difficulty?

How about when ----------?

Was it the sort of relationship where both of you supported the other?

Could either of you be strong in order to help the other?

Would you have felt lost without him/her?

Did either of you ever go away for a short period of time?

How did you cope on your own?

Did you make decisions together?

IF NOT: Who made the decisions?

What sort of arrangements did you have about money when you were together?

Was s/he usually reliable about that?

HELPLESSNESS Did you feel you had much influence over him/her?

Could you get him/her to do what you wanted?

QUARRELS Most couples have arguments from time to time.

How often did you argue?

Would you often get irritable with each other?

When did that start?

What used to happen? Did you ever call each other names, or run down each other's families, or shout?

What sort of things would you argue about?

Did you ever sleep separately, or part after a quarrel

Or not talk to each other? For how long?

Did you ever come to blows?

Did your partner ever threaten you with violence?

IF YES: How often?

When was the first time?

Were either of you ever injured? How often?

Was there ever any serious injury?

GET DETAILS OF DIFFICULTY:

Did your partner ever pressure you to have sex with him/her when you didn't want to?

What did s/he say/do?

How often did that happen?

Was there anything about your sexual relationship that made you feel uncomfortable?
Did your partner ever complain about your sexual relationship?

Was s/he ever unhappy with it?

As you know in some relationships, one partner gets involved with someone else of either sex.

Has anything like this happened with you? To you?

To your partner?

PROBE: Or when have you been suspicious?

PROBE: When was this?

How long did it go on for?

NOTE: When questioning subject about current boy or girlfriend, spouse or cohabiting partner, make sure you have elicited 2 0r 3 specific encounters (for Westen q-sort purposes). Subject should describe what happened in each incident, what subject was thinking and feelings, what sense subject made of why partner did what s/he did, and what happened in the end. The purpose is to get a sense of how complexly the subject thinks, the affective quality of the interaction, and how much subject actually cares about partner and attends to his/her needs.

PARTNER'S ANTISOCIAL PERSONALITY

(IN ADDITION TO DIFFICULTIES ALREADY OUTLINED)

Was your partner very impulsive?

Did s/he fail to plan ahead?

IF YES: Did this lead to problems?

What sort of thing?

Was s/he very reckless?

For example, would s/he speed when driving or drink and drive?

Did this lead to problems?

Would s/he often lie?

About what sort of things?

Did this lead to problems?

PARTNER'S CRIMINAL RECORD

Was your partner ever involved in the courts or did/he have a criminal record?

IF YES: Any prison sentences?

How long for?

For what crime?

Did that happen while you were together?

PARTNER'S PSYCHIATRIC TREATMENT

Did your ex-partner ever suffer from depression or psychiatric illness?

Was s/he ever treated for that?

Did that happen while you were together?

Was s/he ever in psychiatric hospital?

ALCOHOL Did your ex-partner drink much alcohol?

IF YES: Did s/he ever get drunk? How often?

How soon did that happen after you met him/her?

DRUGS Do you know if s/he had ever taken drugs?

IF YES: Has it been a problem?

How soon did you realize that after you met him/her?

END OF RELATIONSHIP/CHANGE IN QUALITY

CHANGE IN QUALITY

Did the relationship change very much while you were together?

In what way?

Why was that?

CRISES — When was that?

Did it lead to a lot of rowing?

Did you confide in each other at that time?

Were you less close?

SEPARATION — How old were you when you finally separated (what year was it?)

Had you ever separated before that time?

IF YES: How old were you then?

How long was that for?

How many times did you separate during the time you were together?

Who left whom? Why was that?

Was it an amicable parting or was there a lot of tension associated with it?

What exactly happened?

CRISES — Did you have any problems with him/her after you split up?

Financial? Custody? Pestering?

IF RELEVANT: What arrangements did you have about the children?
Did it have a big effect on the children? In what way?

IF NOT ALREADY COVERED:

ADVERSITY — Were there any problems associated with the relationship? What?

Probe about the following possible crises:

INCREASE/DECREASE IN INTERACTION Include partner's absence due to working away from home or imprisonment. Take into account isolation, stigma, lack of help with children etc. Take into account the amount the partner is away and degree of contact.

CRISIS/BREAKDOWN IN RELATIONSHIP Reflect here strain and breakdown in the relationship. Include quarreling, tension and violence. Take into account frequency, persistence and pervasiveness of negative atmosphere. Also separations and rejections.

PARTNER'S DRINK/DRUGS/GAMBLING/CRIMINAL BEHAVIOR Cover here the negative impact of such behavior on the relationship.

INFIDELITIES AND EXTRA-MARITAL RELATIONSHIPS Bear in mind the closeness of the relationship (e.g., whether married/cohabiting or boyfriend), the degree of deceit involved, reaction of others etc. The extent to which S is likely to be hurt, relationship jeopardized etc.

TENSION OR DISINTEREST IN RELATIONSHIP Rate the disinterest shown either by partner or S in the relationship and the extent to which this leads to tension and lack of interaction.

SEXUAL PROBLEMS Rate lack of sex in a relationship where it leads to strain and conflict. Any force used by partner should be reflected. Also rate here non-health aspects of STDs.

PARTNER'S ILL HEALTH/ACCIDENTS Take into account partner's ill-health; consider S's nursing role; effect on his employment etc.

DEATH OF PARTNER Take into account the aftermath of partner's death. A bereavement difficulty can be reflected for a one year period.

DIFFICULTIES OVER LEGAL ASPECTS OF SEPARATION/DIVORCE (INCLUDING SOLICITOR CONTACT) Rate issues here to do with impending separation, or after separation in the period partner harasses her.

SEXUAL IDENTITY DIFFICULTIES Rate difficulties in the partner relationship(s) or with others resulting from issues such as homosexuality.

PROMISCUOUS SEXUAL BEHAVIOR DIFFICULTIES Rate only if S's sexual promiscuity leads to dangerous behavior re health or safety.

FOR EACH ADVERSITY:

DATE AND PHASE: How old were you when that happened?
(Establish partner and living place and hence phase)

LENGTH OF ADVERSITY

How long did the problem go on for?
When was it at its worst?

AGENCY IN ADVERSITY

Did you ever feel you were responsible for bringing it about?
Do you think anyone else was responsible?

REPEAT FOR EACH PARTNER

II. EDUCATION/WORK

Were you studying or working during this phase?

IF STUDY:

Did you take any exams before leaving school?

Did you do any further training, or get any further qualifications?

Did you have any problems to do with your education at that time?

PROBE RE:

EDUCATION

LACK OF EDUCATION S's Education: dyslexia, illiteracy, inability to spell or write English.

FAILURES IN EDUCATION S failing exams; other education difficulties of subject.

IF WORK: How did you come to get your first job? What did you do?

Did you change jobs during this period?

How many jobs did you have during this phase?

How long did your longest job last?

NOTE: IF THE SUBJECT HAS HAD FEW JOBS IN THIS PHASE, OBTAIN AN ACCOUNT OF REASONS FOR CHANGES: IF MANY, ESTABLISH THE PATTERN IN EACH PERIOD:

What was the reason you left that job? Did you have another one lined up?

Did you think it likely you would be able to get another one?

What did you base that on?

How did you come to get the next job?

You had several jobs around (year), why was that?

NOTE: IF REASONS FOR CHANGES OF JOB ARE NOT CLEAR:

Did you leave a job without knowing what you would do next?

Did you leave your job/s because of difficulties with the boss, or other people at work? What happened? How often?

Have you ever been sacked?

IF YES: When was that? Why were you sacked?

Were there any other times?

ABSENT/LATE Have you ever taken days off from work (apart from holidays) when you should have been there?

IF YES: Why was that? How often did that happen?

IF ILL: What was the problem? Did you see your GP? Did you get a sick note?

Were you ever late for work?

UNEMPLOYMENT Were you unemployed at all during this phase?

IF YES:

PROBE FOR NUMBER OF TIMES AND DURATION OF EACH TIME

Did you look for a job when you were out of work?

What did you do?

How often did you, e.g., go to the job center, write letters?

Did you get interviews? What happened at them?

What was the reason you didn't get that job (those jobs)?

IF NOT LOOKING FOR WORK:

What was the reason you were out of work?

Did anything prevent you from looking for a job?

Did you want to work?

NOTE: WHERE RELEVANT, CHECK THE PREVAILING LEVEL OF EMPLOYMENT IN THE AREA, IN JOBS OF THE KIND FOR WHICH THE SUBJECT IS TRAINED/SUITABLE.

Did you know other people of your age in your line of work?

Did any of them have jobs?

CRISES Did you have any other problems related to work during this phase?

PROBE FOR:

WORK

DIFFICULTY FINDING WORK/TIME OFF S's unemployment, difficulty finding work, retirement. Sick leave, time off work, strikes.

DIFFICULT WORK CONDITIONS S's long hours, strain. Working at below trained level etc. Lack of time off, low pay.

NEGATIVE WORK RELATIONSHIPS Problems over promotions, sexual harassment at work, negative interactions, work gossip, office politics, etc.

LEGAL DIFFICULTIES RE WORK

FOR EACH ADVERSITY:

DATE AND PHASE: How old were you when that happened?
(Establish partner and living place and hence phase)

LENGTH OF ADVERSITY
How long did the problem go on for?
When was it at its worst?

AGENCY IN ADVERSITY
Did you ever feel you were responsible for bringing it about?
Do you think anyone else was responsible?

NOTE: Before concluding work section, make sure subject has described the people s/he works with at present (if working). Ask subject to describe 2 or 3 specific encounters at this job or a previous one. Probes are the same as those on p. 12 in relationships for Westen q-sort.

III. FINANCE

MONEY CRISES

Did you have any serious problems to do with money?

What happened?

PROBE ABOUT THE FOLLOWING POSSIBLE CRISES:

FINANCE

FINANCIAL PROBLEMS Debts, poverty, loan sharks, borrowing off close others

POSSESSIONS Burglaries, thefts, loss of valuable possessions

LEGAL DIFFICULTIES INVOLVING POSSESSIONS Social security frauds

OTHER

FOR EACH ADVERSITY:

DATE AND PHASE: How old were you when that happened?
(Establish partner and living place and hence phase)

LENGTH OF ADVERSITY How long did the problem go on for?
When was it at its worst?

AGENCY IN ADVERSITY Did you ever feel you were responsible for bringing it about?

Do you think anyone else was responsible?

IV. SOCIAL ARENA

A. FAMILY OF ORIGIN

Did you have any problems with your parents or siblings?

PROBE ABOUT THE FOLLOWING POSSIBLE CRISES:

FAMILY OF ORIGIN (Parents/surrogate parents & siblings)

INCREASE/DECREASE IN INTERACTION Difficulties associated with lack of contact; too much contact with family.

CRISIS BREAKDOWN IN RELATIONSHIP Arguments & rows, breaking off contact.

FAMILY MEMBERS ANTISOCIAL BEHAVIOUR Extent to which family members criminal behavior impinges on S.

FAMILY MEMBERS PSYCHIATRIC HEALTH/SUBSTANCE ABUSE Take into account extent to which this impinges on S.

FAMILY MEMBERS ILL-HEALTH/ACCIDENTS Take into account the extent to which these impinge on S, or are life-threatening, stigmatizing, e.g., AIDS etc.

DEATH OF FAMILY MEMBERS Problems associated with deaths of family members.

LEGAL DIFFICULTIES INVOLVING FAMILY Inheritance disputes

FOR EACH ADVERSITY:

DATE AND PHASE: How old were you when that happened?
(Establish partner and living place and hence phase)

LENGTH OF ADVERSITY
How long did the problem go on for?
When was it at its worst?

AGENCY IN ADVERSITY
Did you ever feel you were responsible for bringing it about?
Do you think anyone else was responsible?

B. FRIENDS

I'd like to ask you about your friends and acquaintances during this phase.

Were there people who you saw regularly? (Or others who were friends but who you saw less often?)

NOTE: OBTAIN THE NAMES OF UP TO 5 FRIENDS

How often did you see X? How long had you known X?

How did you meet? What was her/his age at the time?

What sort of things did you do when you met?

Did you ever turn to X for practical help?

Did you talk about important or personal things together?

Did you have any friends whom you knew for more than 2 years?

Did anything prevent you from getting to know people during that phase?

DISCORD

How often did you quarrel with your friends?

NOTE: IF OTHER THAN INFREQUENT:

How often did you quarrel?

For instance, did you call each other names?

Or come to blows?

Can you give me an example?

Did that ever lead to you not talking to each other for a while?

Did you have friends with whom you had a falling out?

Were there any you said you would never speak to again?

CRISES — Did you have any other problems or crises with close friends in this phase?

NOTE: Probe for betrayals, revelations, psychiatric or health problems of friend that impinged on subject, death of a close friend, etc.

FOR EACH ADVERSITY:

DATE AND PHASE: How old were you when that happened?
(Establish partner and living place and hence phase)

LENGTH OF ADVERSITY
How long did the problem go on for?
When was it at its worst?

AGENCY IN ADVERSITY
Did you ever feel you were responsible for bringing it about?
Do you think anyone else was responsible?

NOTE: When asking about friendships in current phase, make sure you know whom subject regards as his/her closest friends and ask for 2 or 3 specific encounters with adult friends (this can be with one friend or different friends). Again, probe in Westen style for q-sort (see p. 12).

C. NON-SPECIFIC SOCIAL CONTACTS

Apart from the people we have just been talking about (family, close friends, partners), how did you get on with people in general during that phase?

NOTE: ALLOW SUBJECT TO EXPAND

How did you get on in social gatherings such as parties?

How often did you go to events like that?

Would you talk to people you hadn't met before?

What would you talk about?

What about with neighbours?

How many did you know to talk to?

How did you get to know them?

What did you discuss with them?

Did you do other things with them?

Did you ever have any difficulties with the neighbours?

Did you meet people in groups, for instance pubs or clubs?

Or evening classes?

What did you do there? How often?

How many people did you know there?

Did you get into conversations? What about?

Were you active in any organisations?

(Such as sports clubs or trade unions?)

What did you do? How often?

How many people did you know there?

Did you talk to them about things other than _____?

IF RELEVANT:

Did you talk to parents at the children's school? Or in the street?

SATISFACTION Would you have liked to meet up with more people during this phase? Or more often?

Or talk about different things? Or share other activities?
Or get more involved in conversations/activities?
Did anything make it difficult for you to do that?

D. TRANSIENT RELATIONSHIPS

Apart from the people we talked about just now, do you find that you have relationships where you get on well to start with, and things don't work out, or people let you down?

WHERE APPROPRIATE: I mean where you see a lot of someone, but it only lasts for a short time.

IF NO: GO TO NEXT SECTION

IF YES: How often has that happened?

In general, how did you get on with these friends?

Have there been any, with whom you argued a lot or even had fights?

Can you give me an example?

Have any of the relationships ended with arguments, or fights?

WHERE INDIVIDUALS HAVE LARGE NUMBERS OF TRANSIENT RELATIONSHIPS, IT IS NOT NECESSARY TO ESTABLISH EXACT NUMBERS OF THE DURATION OF EACH ONE.

DISCORD: Rate 'Marked. Not pervasive.' Where there were repeated arguments often leading to breakdown only in some relationships.

TRANSIENT RELATIONSHIPS: These are relationships with people seen at least every fortnight where there were joint activities, confiding, or practical help, and there has been either a clearly declared break, or at least one year that has elapsed since regular contact.

E. CHILDREN

Did you have any problems or difficulties with any of your children (partner's children)?

PROBE ABOUT THE FOLLOWING POSSIBLE CRISES:

S'S CHILDREN/SURROGATE CHILDREN

CONDUCT PROBLEMS Child's truancy, delinquency, stealing, substance abuse. Police contact for such behaviour.

SUBSTANCE ABUSE Child's alcohol or drug use.

PSYCHIATRIC DISORDERS Child's hyperactivity, depression, anxiety, eating disorder, self-mutilation, etc.

SEXUAL BEHAVIOR Child's pregnancies, induced abortion, etc. Underage sex, promiscuity.

ABUSE OF S'S CHILDREN Sexual or physical.

INTERACTIONS Arguments, fights, crisis in relationship breaking off contact with children; separations from children.

HEALTH Handicaps, ill-health, hospital attendances, accidents to children.

DEATH Deaths of children (perinatal deaths 2 days - 1 year) plus any later deaths.

ADOPTEES/SURROGATES Problems because S not natural parent. Problems re S's child learning of own adoption.

PREGNANCIES/MISCARRIAGES (Details of pregnancy history should have come up in the Transitions/Planning interview, but if more detail is needed for ALPHI ratings probe here).

FOR EACH ADVERSITY:

DATE AND PHASE: How old were you when that happened? (Estab. partner, phase)

LENGTH OF ADVERSITY
How long did the problem go on for? When was it at its worst?

AGENCY IN ADVERSITY Did you ever feel you were responsible for bringing it about?
Do you think anyone else was responsible?

F. EX-PARTNERS: (IF RELEVANT) Did you have any crises with your ex-partner?

PROBE ABOUT THE FOLLOWING POSSIBLE CRISES:

EX-PARTNERS

HARASSMENT & VIOLENCE Harassment by ex-partner; violence; rape; jealousy over S's boyfriends/girlfriends/partners

LEGAL ASPECTS Legal problems, e.g., custody & child care disputes; maintenance disputes

DISPUTES OVER CHILDREN Ex-partner turning children against her/him, manipulating children, etc. Abusing children

---

FOR EACH ADVERSITY:

DATE AND PHASE: How old were you when that happened?
(Establish partner and living place and hence phase)

LENGTH OF ADVERSITY
How long did the problem go on for?
When was it at its worst?

AGENCY IN ADVERSITY
Did you ever feel you were responsible for bringing it about?
Do you think anyone else was responsible?

V. ANTISOCIAL BEHAVIOUR

In this phase, did you find that you ever had disagreements or arguments with people outside the family? .

I mean ones that end up with abuse, or threats.

IF NO: GO TO QUESTION A.

IF YES: How often did that happen during this phase?

PROBE TO ESTABLISH CIRCUMSTANCES, FREQUENCY, AND SEVERITY OF ARGUMENTS.

A. Were you ever in any fights?

IF NO: GO TO QUESTION B.

IF YES: How often did that happen during this phase?

PROBE TO ESTABLISH NUMBER, DATES, AND SEVERITY OF FIGHTS, AND CONVICTIONS AND SENTENCES.

THE INTERVIEWER WILL NEED TO USE JUDGMENT ON WHETHER TO PROBE SPECIFICALLY FOR CRIMES SUCH AS MUGGING OR ARMED ROBBERY.

B. Were you involved in any incidents where violence was used?

THIS IS A NEUTRAL PROBE TO BE USED SENSITIVELY TO GIVE THE SUBJECT A FURTHER OPPORTUNITY TO REPORT FIGHTS, ETC.

AGGRESSIVE BEHAVIOUR OUTSIDE THE FAMILY: quarrelsome behaviour includes the use of abuse, verbal threats of violence, or provocative behaviour. Rate 2 where this occurs only in one particular relationship, or with others when it is not part of the subject's usual behaviour. Rate 1 for incidents of less severity and frequency than the above, or for regular irritable assertive behaviour in public places.

FIGHTS AND OTHER ACTS OF VIOLENCE: the rating of severity of violence refers to the most severe outcome of any episodes. Moderate injuries are multiple bruises, or cuts that require stitches. Major injuries are either broken or fractured bones, or internal injuries, or injuries that could clearly have endangered life irrespective of actual injuries.

NEGOTIATIONS WITH PEOPLE- CURRENT + baseline period

Most of us have to deal with people we do not get to know as friends - such as shopkeepers, school teachers, social security officers, doctors or plumbers.

What sort of contacts with people like this have you had recently?
What about ....

Talking to teachers.
Arranging appointments with the doctor, hairdresser, etc.,
Going to the housing department

REFER TO AREAS PREVIOUSLY MENTIONED

What happened when you ..... (OBTAIN A RECENT EXAMPLE)?

What do you do if work isn't done properly, or goods are faulty, or you are short changed? When did that last happen? What did you do?

Have you had any trouble with people in these situations?
For instance with people trying to cheat you, or treat you unfairly?
Has that ever led to arguments? For instance where abuse has been used?
Or threats? Or fighting?
Have you had disagreements for any other reasons in these situations?

RANGE-CURRENT
Rate '1' where the subject handles most or all areas of negotiation. Rate '2' where a significant number of areas is not dealt with by the subject, and '3' where most are not handled by the subject.

ASSERTIVENESS-CURRENT
The rating '1' is made where the subject has actively negotiated with respect to major items (such as finances, health, education, or housing) in the face of significant opposition or difficulties. Rate '2' where there has been active negotiation only over everyday items (such as faulty goods), or only where there has not been significant opposition or difficulty. '3' is rated where the subject has only undertaken basic activities, such as making purchases or arranging appointments at the doctor, but has not asserted rights or wishes in transactions. In some cases others may have taken advantage of the subject.

DISCORD-CURRENT
Rate '2' where the subject reports occasional arguments during negotiations. Often these will be part of an active negotiating style. Where arguments or an aggressive manner are seen regularly but not frequently, and are not pervasive, rate '3'. '4' is rated where the majority of negotiations are accompanied by an irritable, argumentative, or aggressive manner, or where there have been physical aggression or serious threats on fewer occasions.

RELIANCE ON OTHERS-CURRENT

IF SUBJECT HANDLES FEW OR ZERO NEGOTIATIONS:
Does anyone else in the family handle these things? Or outside the family? What does he/she do? Would you like to deal with more things yourself? Does anything prevent you from ..... (GIVE AN EXAMPLE)

IF SPOUSE HANDLES MOST NEGOTIATIONS:
Was that agreed between you? What about when C (spouse or cohabitee) is ill or not there?

What did you do before you were married/lived together?

IF FAMILY OF ORIGIN OR OTHER AGENCY:
How long has ... helped out in this way? How did you manage before then?

NEGIOTIATIONS WITH PEOPLE-PREVIOUS

What about in your twenties? Were there any differences in what you did then compared with now?

PROBE AS ABOVE TO ESTABLISH WHETHER COPING AGE 21 TO 30 WAS DIFFERENT.

IF IMPROVED: You said that now you do things (e.g. .....) that you didn't do in your twenties. What prevented you (make it difficult) at the time? In what way has that changed?

IF MORE IMPAIRED: You said you used to do things (e.g. ....) you don't do now. What prevents you from doing them? (What makes it difficult?) In what way has that changed?

RELIANCE: 'Significant' reliance is rated where the spouse does much of the negotiations and this is agreed, expected, and there is evidence that the subject has been able to function in this area. Rate reliance as 'marked'where there is evidence that the spouse or other person, compensates for major difficulties with negotiations.

VI. MISCELLANEOUS

CRISES — Did you have any other crises or problems during this phase?

What happened?

PROBE ABOUT THE FOLLOWING POSSIBLE CRISES:

S'S HEALTH DIFFICULTIES

SERIOUS (life threatening) ILLNESS: cancer, heat disease, etc.

LONG-TERM HEALTH DIFFICULTIES (non-life threatening): diabetes, rheumatism

HOSPITALS STAYS; operations

HANDICAPS: blindness, deafness

PERSONAL APPEARANCE: obesity, handicap, disfigurement

CRIME/LEGAL

S's POLICE CONTACT: theft, drug dealing, etc.

PROBLEMS ARISING FROM DRUG USE: negative interaction with drug dealers, conflicts about reporting to police, etc.

HARASSMENT: anonymous telephone calls, letters

ATTACKS FROM STRANGERS: mugging, rape

RACIAL/SEXUAL HARASSMENT

OTHER DIFFICULTIES

GEOPOLITICAL DIFFICULTIES: war, deportation

FOR EACH ADVERSITY:

DATE AND PHASE: How old were you when that happened? (Estab. partner, phase)

LENGTH OF ADVERSITY
How long did the problem go on for? When was it at its worst?

AGENCY IN ADVERSITY Did you ever feel you were responsible for bringing it about?

Do you think anyone else was responsible?

CHANGE POINT

ASK ABOUT ENDING OF ONE PHASE AND BEGINNING OF THE NEXT:

REASON FOR CHANGE

What was the main reason for the phase ending?

REASON FOR EXIT FROM PHASE

EDUCATION: e.g., leaving home to go to university.

WORK: e.g., changing career.

REPRODUCTION: e.g., birth of child leads to change in housing.

HOUSING: e.g., eviction forced to move some distance away.

MONEY/POSSESSIONS: e.g., having to leave to escape debt/debt collectors.

CRIME/LEGAL: on the run to avoid police, harassing partner.

HEALTH/TREATMENT/ACCIDENTS: retirement through health reasons.

MARITAL/PARTNER: RELATIONSHIP: e.g., separation from partner; moving in with new partner.

OTHER RELATIONSHIPS: e.g., leaving home because of difficulties with parents or flat mate.

CHILDREN: e.g., move to be nearer adult children.

DEATHS: death of partner or parents involving life changes.

MISCELLANEOUS

ADVERSITY Were there problems associated with the change?

What sort of things?

PROBE:

Financial, housing, marital, work, children, etc.

What about the new situation that you then got into?

PRIOR AWARENESS/DIFFICULTIES

Did you realise beforehand that these problems were likely to arise?

Was there any particular reason why the change happened at that particular time?

Whose idea was it?

Was it your decision?

Had you been planning it for a while?

If so, for how long?

What did you do practically?

IF NOT: How long had it been in your mind?

POSITIVE ELEMENTS

Were there positive aspects to the change?

What sort of thing?

COPING AND INDEPENDENCE : current + baseline period

Who deals with everyday things like buying food, washing clothes, keeping the home/flat clean, or making meals?
Or buying clothes, or items for the home?
Or attending to essential repairs to the house?

PROBE RE COPING BY SUBJECT:

How do you go about .... (SHOPPING, WASHING, CLEANING, PREPARING MEALS, DOING REPAIRS OR ORGANIZING REPAIRS)

PROBE TO ESTABLISH PLANNING ROUTINES, AND LEVEL OF COPING
e.g. Do you ever find that you have ... (no clean clothes or food)?
Do you get behind with ... (repairs, cleaning the house)?

IF DAY TO DAY COPING INCLUDES PARENTING:
Do you cook the children's meals? Do they have regular meal times?

Who takes them to school? And brings them home? Is someone in when they get home?

What about when you go out? For instance in the evening? Who looks after them then?

And what about finances? Who deals with them?
Who pays the bills? Who decides what money can be spent?
How do you plan your budgeting?

Have you ever run up debts, or got behind on hire purchase payments?
IF YES: How did that happen?

WHERE APPROPRIATE: What is the longest you have been in debt?
How much was involved?

Have you ever tried to avoid making payments? Or got into trouble because of debt?

DAY TO DAY TASKS: Rate '1' where there is efficient management of day to day needs, based on plans and/or routines, but with appropriate flexibility. '3' is rated where there are some regular major problems; for instance clothes unwashed, esential repairs left undone. '4' indicates major difficulties in all areas of day to day coping.
PARENTING: Rate '1' where there are clear routines with appropriate flexibility, and reliable arrangements for school and (where required) substitute caretaking. Where there is a major deficit in one of the 3 areas rate '3' and in 2 or 3 of these areas rate '4'.
DEBTS: A debt is money owed outside the rules of an agreement. Thus money due on an overdraft, bank loan, or H.P. is not a debt unless the subject has fallen outside the terms of the agreement. Ratings of debts are made where they have lasted more than 6 months. Minor is rated where the sum is less than £100, Moderate £100-500, and Major over £500.

RELIANCE ON OTHERS-CURRENT

IF SUBJECT DOES LITTLE DAY TO DAY COPING:
Would you like to do more? Does anything make it difficult for you to do more?

IF SPOUSE DOES MAJORITY OF COPING DAY TO DAY:
Did you agree that between you? Does he/she talk to you before .... (e.g. making a purchase). Do you have any say in that area? What about when C (spouse or cohabitee) is ill or not there?

And before you were married/lived together; how did you manage then?

IF MAINLY DONE BY FAMILY OF ORIGIN OR OTHER AGENCY:
Has there been a time when you did any of these things?

COPING AND INDEPENDENCE-PREVIOUS

And what about in your twenties? How did you cope then?

PROBE AS ABOVE TO ESTABLISH WHETHER COPING AGE 21 to 30 WAS DIFFERENT.

IF IMPROVED: You said that now you do things (e.g. ...) that you didn't do in your twenties. What prevented you at that time? In what way has that changed?

IF MORE IMPAIRED: You said that you used to do things you don't do now. What prevents you from doing them? (What makes it difficult?) In what way has that changed?

RELIANCE
'Significant' reliance is rated where the spouse (usually the wife) does much of the day to day coping and this is agreed, expected, and there is evidence that the subject can cope. Rate reliance as 'marked' where there is evidence that the spouse compensates for major difficulties in the subject's day to day coping.

THE ANNA FREUD CENTRE
LONG-TERM FOLLOW-UP STUDY

PERSONALITY DIAGNOSTIC INTERVIEW

DREW WESTEN, PhD

ABRIDGED VERSION FOR USE WITH
THE FOLLOW-UP STUDY PROTOCOL

ADAPTATION OF DREW WESTEN OBJECT RELATIONS CLINICAL INTERVIEW FOR USE IN THE FOLLOW-UP STUDY

General principles:
This interview should be conducted as a clinical interview, with probing as appropriate based on the interviewer's clinic skill, empathy, and hypotheses that emerge in listening to the material. As in clinic interviewing, if the subject says something with an ambiguous meaning, or which could lead to important information, the interviewer should ask about it. If interview questions become redundant because the answers are clear from previous responses, do not ask question (exception: always ask the relationship questions noted in **bold** print). Interviewers should feel free to make *minor* wording changes to fit their interviewing style. The interviewer should take notes during the interview on comments the subject makes that s/he wants t go back and inquire about, as well as comments of relevance to coding the interview. If Q-sorting from this interview, *be sure to do so within 24 hours after the interview*, after reviewing your notes. Delaying beyond 24 hours adds considerable error because subjects frequently volunteer important acts about themselves at the beginning of the interview that are forgotten by the end.

1. Tell me a little about yourself, like who you are, what you do, and what you're like as a person.

2. You have already described much of your childhood in the previous interview, so here we'll be concentrating mainly on your adulthood.

If not already established: Do you have brothers and sisters? (If no, skip to question 3).

Could you describe them and your relationship with them?

Now I'd like you to describe a specific encounter with one of your brothers or sisters. If subject is not sure by what you meant by encounter you can clarify by saying that you're looking for something that stands out of their mind who will illustrate their typical relationship, it could be really meaningful, really pleasant or unpleasant, as they want - whatever comes to mind. (If gives example from childhood, probe for current experience)

Ask for one more if more than one sibling, and this time with a different sibling.

Now I'd like you to describe one more encounter.

Possible probes for information's not given spontaneously when telling his encounter; what led up to the event recounted, what both people were thinking and feeling, and the outcome; in a situation where subject had difficulty in finding an encounter, you can use those probes at the beginning.

3. Now I'd like to know a bit about your friendships.

Who are your closest friends? **Could you tell me about your relationship with one of them - what it is like?**

As previously, ask for two specific incidents, either with one friend or different friends if subject prefers.

Are you involved in many groups or activities with other people, like clubs, churches, or athletic groups?
What do you do for fun?

4. **Can you tell me a bit about your more recent romantic relationships - what have they been like?** Do your relationships tend to be stormy or smooth?
If not already known you can ask if subject is currently married or romantically involved with someone?*
If Yes: Could you tell me about the relationship?
Again, ask for two specific encounters.

Are you satisfied with your sexual life? Are there things that made you feel uncomfortable sexually, or that you don't like to do, that your partners have wanted to do? Do your partner ever complained about your sexual attitudes or behaviours? Is there anything about your sexual life that leave you unsatisfied or that you will like to explore more?

5. Could you tell me a little bit about your work? (probe to get a flavour of behaviour patterns, also to find sign of obsessionality)
Ask about the most recent job and about the people who work with subject.
Again ask for two specific encounters at recent or previous jobs.
Are you satisfied with your financial situation? (probe for attitude towards money)

6. Do you have children? (This will probably be known to interviewer at this point so rephrase the question appropriately).
If subject has children, ask to describe two incidents with them. If subject has more than one child, elicit information on each child.
If subject does not have children, elicit one vignette on any caretaking relationship in which the subject is the caretaker.
Are there situations in which other people take care of you?
How do you feel about being taken care of - do you like it?
Does it bother you?
Can you give me an example of a time someone took care of you that stands out in your mind as typical, meaningful, or problematic?

7. *If subject is currently in therapy, ask the following:*
Can you tell me about your relationship with your current therapist?
(Ask for one or two vignettes)

8. You have described a lot of encounters you've had with different people, in previous parts of the interview as well.
Is your personality different when you're with different people?
(Probe with mother, spouse, at work, etc.)
How do these aspects of you fit together?
Do you ever feel like the parts of you *don't* fit together, or that you don't know who you are?
Has your personality changed a lot since you were a child, or are you basically the same person you always were?

If so, is there some core part of you that is the same?
How do you usually feel about yourself?
Do your feelings about yourself change a lot from moment to moment, or from day to day?
Have you noticed any differences in the way you are with men and with women?
Do you tend to feel more comfortable with one or the other?
(Probe for one typical vignette with each if subject report difference in level of comfort)
What goals and values are most important to you or mean the most to you?
Does life ever seem meaningless to you?
How do you picture yourself in five years? In ten years?
(Probe, what are you doing, feeling, who are you with)
What do you hope to accomplish in your lifetime - what are your aspirations?
What is your biggest fear about what or who you could become?

9. I've asked you a lot of questions. How has this been?
   Is there anything we haven't covered that is really important in understanding you as a person?
   Is there anything else you would like to add, or anything you'd like to ask?

APPENDIX 4.13. DEMOGRAPHICS FORM

DATE OF INTERVIEW _____
DD MM YY

ID _____

HOW OLD ARAE YOU? AGE_____

WHAT IS YOUR DATE OF BIRTH? D.O.B_____
DD MM YY

WHERE WERE YOU BORN?_____

WHERE WERE YOU BROUGHT UP?_____

MARITAL STATUS

ARE YOU MARRIED OR LIVING WITH SOMEONE? YES/NO

Record: SINGLE/MARRIED/COHABITING

IF YES: How long has that been for? _____MTHS/YRS

When did you cohabit/marry? _____ (DATE)

IF NO: DO YOU HAVE A BOYFRIEND? YES/NO

If yes: How long have you known him for? _____ MTHS/YRS

_____ (DATE)

HAVE YOU EVER BEEN DIVORCED/SEPARATED OR WIDOWED? YES/NO

IF YES: When was that? _____ (DATE)

So you were how old? _____ (AGE)

Did you leave your partner, or did s/he leave you - or was it mutual?

Patrtner left/Subject left/Neither/Both

SCHOOL / WORK HISTORY

What sort of secondary school did you go to?_____

e.g. comprehensive, grammar, secondary modern, independent.

(Did you take the 11+ exam? YES/NO
If yes:
(Did you pass?) YES/NO

Did you get any GCEs or CSEs?
IF YES: How many?_____

What age were you when you left school?_____

Did you do any training after you left school? YES / NO
IF YES: What?

How old were you when you got your first full-time job?_____

DO YOU WORK NOW? YES/NO
IF YES:

What is your job?

_____

Are you a supervisor/ manager? YES/NO

Are you self-employed? YES/NO

HOW MANY HOURS A WEEK DO YOU WORK? _____HRS
(distinguish especially 30+hrs (full-time)

HOW LONG HAVE YOU HAD THAT JOB? _____MTHS/YRS

IF NO:

What was your last/main job?_____
When did you leave your last job? _____ (DATE)

DOES YOUR HUSBAND/PARTNER WORK? YES/NO

IF YES: What is his job?_____
Is he a manager/supervisor or foreman? YES/NO
Is he self-employed? YES/NO

IF NO: What is his usual/latest job?_____
Was he a manager/supervisor or foreman? YES/NO
Was he self-employed? YES/NO

CHILDREN

HOW MANY CHILDREN DO YOU HAVE? _____
Do any of them live away from home? YES/NO
IF YES: GET DETAILS OF WHERE

HAVE YOU OR YOUR PARTNER HAD ANY OTHER PREGNANCIES?
How old were you? _____ (DATE)

FAMILY OF ORIGIN

II. PARENT FIGURES - NATURAL AND SURROGATE

Are your parents still alive?

Was there anyone else apart from your natural parents who brought you up in childhood? If yes: How often do you see them?

	RELATIONSHIP	CLOSE TIE	CONTACT VISUAL	CONTACT NON-VISUAL	DATE OF BIRTH	AGE
14	MOTHER					
15	FATHER					
16	STEPMOTHER					
17	STEPFATHER					
18						
19						

Do you have brothers and sisters? What position are you in the family?

I. SIBLINGS (Full, step and half)

NO.	FIRST NAME RELATIONSHIP (Full,step...)	CLOSE TIE*	CONTACT VISUAL	CONTACT NON-VISUAL	DATE OF BIRTH	AGE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Did any siblings die when you were a child?

III. CURRENT PARTNER AND ALL CHILDREN (WHETHER HOUSEHOLD MEMBERS OR NOT)

NO.	FIRST NAME RELATIONSHIP	CLOSE TIE*	CONTACT VISUAL	 NON-VISUAL	DATE OF BIRTH	AGE
20	CURRENT PARTNER					
21	CHILD					
22						
23						
24						

V. PREVIOUS COHABITING PARTNER

Have you been married before, or lived with anyone?

30	PREVIOUS PARTNER				N/A	
					N/A	
					N/A	
					N/A	

VI. CURRENT VCOS/ CONFIDANTS (not included above)
If you had a problem of some sort, who would be the first person you would confide in?
Is there anyone you feel very close to apart from your partner or children?
Can you confide in them?

35					N/A	
					N/A	
					N/A	
					N/A	

APPENDIX 4.14. CONSENT FORM

CONSENT FORM

THE ANNA FREUD CENTRE

For the Psychoanalytic Study and Treatment of Children

CONSENT TO PARTICIPATE IN RESEARCH STUDY

I (name) .....

of (address) .....

.....

agree to take part in the research project undertaken at The Anna Freud Centre.

I confirm that the nature and demands of the research have been explained to me and that I understand and accept them.

I also understand that I may withdraw from the research project if I find that I am unable to continue for any reason or at any time.

Signed ..... Date .....

Witnessed by ..... Date .....

Investigator's Statement

I have explained the nature, demands and foreseeable risks of the above research to the subject.

Name ..... Position .....

Signed ..... Date .....

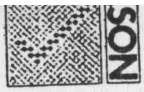
APPENDIX 4.15. THE NATIONAL ADULT READING TEST (NART) PROTOCOL, INSTRUCTIONS AND RATING SHEET

The NART card is given to the subject. The tester has the NART Answer Sheet on which s/he records the errors made. The following instructions are given.

"I want you to read slowly down this list of words starting here." Indicate ACHE. "After each word please wait until I say "next" before reading the next word. I must warn you that there are many words that you probably won't recognize, in fact, most people don't know then, so just have a guess at these, OK? Go ahead."

If the subject fails to wait, this instruction should be repeated as often as necessary. The subject should be encouraged to attempt every word and instructed to guess where necessary. All responses should be reinforced. For example, "That's fine, good" is encouraging without being strictly dishonest. The subject may change a response if s/he wishes to do so but if more than one version is given the subject must decide what is his/her final choice. No time limit is imposed.

CHORD	HEIR	PLACEBO
ACHE	RADIX	ABSTEMIOUS
DEPOT	ASSIGNATE	DETENTE
AISLE	HIATUS	IDYLL
BOUQUET	SUBTLE	PUERPERAL
PSALM	PROCREATE	AVER
CAPON	GIST	GAUCHE
DENY	GOUGE	TOPIARY
NAUSEA	SUPERFLUOUS	LEVIATHAN
DEBT	SIMILE	BEATIFY
COURTEOUS	BANAL	PRELATE
RAREFY	QUADRUPED	SIDEREAL
EQUIVOCAL	CELLIST	DEMESNE
NAIVE	FACADE	SYNCOPE
CATACOMB	ZEALOT	LABILE
GAOLED	DRACHM	CAMPANILE
THYME	AEON	



National Adult Reading Test (NART)

Answer/Record Sheet

Name ..... Date of test .....

Errors

CHORD.....
ACHE.....
DEPOT.....
AISLE.....
BOUQUET.....
PSALM.....
CAPON.....
DENY.....
NAUSEA.....
DEBT.....
COURTEOUS.....
RAREFY.....
EQUIVOCAL.....
NAIVE.....
CATACOMB.....
GAOLED.....
THYME.....
HEIR.....
RADIX.....
ASSIGNATE.....
HIATUS.....
SUBTLE.....
PROCREATE.....
GIST.....
GOUGE.....
SUPERFLUOUS.....
SIMILE.....
BANAL.....
QUADRUPED.....
CELLIST.....
FACADE.....

Errors

ZEALOT .....

DRACHM .....

AEON .....

PLACEBO .....

ABSTEMIOUS .....

DETENTE .....

IDYLL .....

PUERPERAL .....

AVER .....

GAUCHE .....

TOPIARY .....

LEVIATHAN .....

BEATIFY .....

PRELATE .....

SIDEREAL .....

DEMESNE .....

SYNCOPE .....

LABILE .....

CAMPANILE .....

Obtained WAIS results:

Full Scale IQ ☐ Verbal IQ ☐ Performance IQ ☐

NART error score ☐

	Predicted IQ	Predicted-Obtained IQ	Abnormality (%)
Full Scale IQ			
Verbal IQ			
Performance IQ			

NART + Schonell error score ☐

	Predicted IQ	Predicted-Obtained IQ	Abnormality (%)
Full Scale IQ			

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APPENDIX 4.16. LAUNCHING QUESTIONS AND RATING SHEET

I'd like to ask you a bit about your adult life – from when you left home?

LEAVING HOME DATE

How old were you when you left home?

Can you tell me how you came to leave home, what happened?
Did things at home influence you in leaving?

> ALLOW SUBJECT TO RELATE EVENTS SURROUNDING LEAVING HOME AND GOING INTO NEW ARRANGEMENT.

FELLOW TRAVELLER

Did anyone come with you?
Who was that?
Why did they come along?

SECURITY CHARACTER

Were there problems associated with leaving?
What?

PROBE:

Financial, housing, partner, work, relationship parents, siblings etc.

PRIOR AWARENESS OF DIFFICULTIES

IF DIFFICULTIES:

Did you realise beforehand that these problems were likely to arise?
How did this affect you?

PLANNING

Was there any particular reason why you left at that particular time?
Whose idea was it?

Was it your decision?

Had you been planning it for a while?
If so, for how long?
What did you do practically?

IF NO PLANNING:
How long had you been thinking about it?

SOCIAL RESOURCES

Did anyone help you with the situation?
Who was that?
What did they do?

ACCEPTANCE	Were they sympathetic? Anyone else?
REJECTION BY OTHERS	Was anybody in your home or elsewhere very rejecting or critical? Who was that? What did they say or do? Anyone else? Was there any bad feeling involved? Any rows or arguments?
IF YES:	Who was involved? What happened?
	Were you made to feel guilty about leaving?
MATERIAL RESOURCES	Was there anything that made leaving easier or harder? E.g. having enough money, somewhere to live, transport etc.
PERSONAL RESOURCES	How well do you think you coped with leaving home? Was there anything that helped you to cope? E.g your particular skills or prior experience.
ATTITUDINAL CONSTRAINTS	Was there anything in you that made it harder for you to cope well ? E.g. you were too proud/shy to ask for help You weren't independent enough? You were too headstrong? Do you now wish you had handled it differently?
SOCIAL CONSTRAINTS	Was there anything about other people's attitudes that made it more difficult to cope well? What was that? Whose attitude? What did ..... say or do? How did you deal with that?
ENTRAPMENT	Did you feel at all trapped at that time? In what way? Did you do anything about it?
ENTHUSIASM	Did you feel enthusiastic about the new situation? Why was that?
HELPLESSNESS	Did you feel helpless about the situation at all? In what way?
WORK	Did you have a job to go to? What was it?

P Record LAUNCHING PERIOD 9 September 1992

Entered on computer_____

ID___ ___

Rater__ _____

Section One - LEAVING SCHOOL

Date S left school P40_ _ _ _
DD MM YY

Date when began post-school training P41_____ ___
DD MM YY

S's post-school training
Rate highest and only rate if training completed.
0. None
1. Youth Training Scheme
2. Technical/ secretarial e.g. certificate in childcare, hairdressing, carpentry, clerical.
3. University degree or equivalent
4. Semi-professional e.g. nursing, teacher training college.
5. Professional training - post degree e.g. accountancy, lawyer.

P42____ ____

First occupation
Golthorpe-Hope rating 1-36
-1 not in job market e.g. housewife.

P43___ ____

Describe____ _____

Section Two - LEAVING HOME

Summarise circumstances of S's leaving home

Date of first leaving home P44___ ___ ___
(i.e. stops living with parents/surrogates) DD MM YY

Date when S permanently left 'home' P45___ ___ ___
(rate latest date at which s removed her belongings etc. and no longer returned home e.g. college holidays. If only one leaving point then rate same date as P44). DD MM YY

S's reported reasons for first leaving parental home

(Rate -1 if still at home)
1. Leaving for work/ college
2. Leaving to marry/ cohabit
3. Leaving because of pregnancy
4. Leaving to live alone/ flat share
5. Difficulty with parents/ siblings
6. Difficulty re: overcrowding
7. Thrown out
8. Other (e.g. forced to leave institution)

Main reason P46A___ ___

Subsidiary reason P46B___ ___

Did S choose to leave?
0. Yes - no pressure
1. Yes - but pressure from others/ situation
2. No - 'thrown out'
3. Mixture of above P47 ___ ___

Did S 'run away'?
(i.e. leave without planning or informing anyone, in haste).
0. No
1. Yes P48 ___ ___

Difficulties in the home prior to leaving

Rate the degree of difficulties present in the home (i.e. interpersonal problems, gross overcrowding, any abuse etc.).

1. Marked
2. Moderate
3. Some
4. Little/none

Describe:

P49___ ___

Degree to which S's behaviour was ill-considered

Rate the degree to which S behaved without giving appropriate thought/ consideration to her actions in relation to leaving.

1.Marked
2.Moderate
3.Some
4.Little/none

Describe:

P50 ____ ____

Level of initiative taken by S in leaving

Rate the degree to which S takes the initiative in the situation as opposed to following other peoples' leads.

1.Marked
2.Moderate
3.Some
4.Little/none

Describe:

P51 ___ _____

Degree of planning by S

Rate the degree to which S formulated plans and strategies. Consider the length of time over which S actively thought about the problem and her behaviour in seeking resolution.

1.Marked
2.Moderate
3.Some
4.Little/none

Describe:

P52 ____ ___

Section Three - FIRST PARTNER

Date of start of relationship with first significant partner

(As defined by S) P53__ DD MM YY

Relationship with first significant partner named above

0. Boyfriend only : non-sexual relationship
1. Boyfriend only : sexual relationship
2. They subsequently cohabited
3. They subsequently married
4. Other

P54___ ____

Degree of sexual intimacy with first significant boyfriend

(Rate '1: marked' if sexual intercourse)

1. Marked
2. Moderate
3. Some
4. Little/none

P55____ ___

Date of S's first sexual intercourse

P56_
DD MM YY

Relationship to first-intercourse partner at the time

0. First significant partner (as identified above)
1. Other 'serious' partner (e.g. 'serious' boyfriend, cohabitee or husband)
2. Casual friend/ acquaintance
3. 'One-night stand'
4. Other

P57___ _____

Use of contraception at first intercourse?
0. No
1. Yes

P58___ ___

Did first intercourse result in pregnancy?
0. No
1. Yes

P59___ ___

Section Four - FIRST PREGNANCY

Rate all -1 if S has never been pregnant.

Age at first pregnancy?

P60__
DD MM YY

Was S's first pregnancy in a cohabiting relationship?
0. No
1. Yes

P61___ _____

Was S's first pregnancy unplanned?
0. No (i.e. planned)
1. Clearly unplanned
2. Unclear - but no definite plan

P62___ ____

Did first pregnancy come to term?

1. Yes - child stayed with S
2. Yes - child separated from S e.g. adopted away
3. Yes - stillbirth
4. No - miscarriage
5. No - termination

P63____ ____

Describe circusmtances of first pregnancy:

APPENDIX 4.17. A BREAKDOWN OF THE FAMILY OR LIVING SITUATION OF THE FOLLOW-UP SAMPLE AS COMPARED TO THE FULL RETROSPECTIVE SAMPLE

Family or living situation	% of retrospective subjects (n = 763)	% of follow-up subjects (n = 34)	Chi-square df=1	p<
Living with both biological parents	71.3 (n = 544)	82 (n = 28)	1.96	0.1611
Living with one parent	14.7 (n = 112)	9 (n = 3)	0.90	0.3418
Living with adoptive parents	2.9 (n = 22)	9 (n = 3)	3.78	0.0519
Reconstituted family	5.7 (n = 43)	0	2.03	0.1547
Children's home or foster care	3.1 (n = 24)	0	1.10	0.2937
Other, e.g. long-term hospitalization	2.3 (n = 18)		0.82	0.3650

n.s.

APPENDIX 4.18. RGC* SOCIAL CLASS DISTRIBUTION OF PATIENTS' FAMILIES

Social class	I	II	III	IV or V	Chi-square	df
% of retrospective sample (n = 763)	20.5 (n = 156)	43.7 (n = 333)	25.2 (n = 192)	6.2 (n = 47)	5.53	3
% of follow-up sample (n = 34)	29.0 (n = 9)	52.9 (n = 18)	11.7 (n = 4)	5.8 (n = 2)		

n.s.

*According to the RGC classification system, Classes I through V represent the highest to lowest socio-economic groupings.

APPENDIX 4.19. FREQUENCY OF PARENTS' PSYCHOLGICAL PROBLEMS

Parents' symptomatology	% of parents in retrospective sample	% of parents in follow-up sample	Chi-square	df
Psychosis	2.4 (n = 18)	2.9 (n = 1)	118.85**	13
Bipolar disorder	2.5 (n = 19)			
Puerperal depression after birth of patient	3.9 (n = 30)	14.7 (n = 14.7)		
Other depressive episodes	35.3 (n = 269)	41.1 (n = 14)		
Obsessive-compulsive disorder		5.8 (n = 2)		
Other anxiety disorders	18.8 (n = 143)	17.6 (n = 1)		
Personality disorders	9.9 (n = 76)	5.8 (n = 2)		
Drug/alcohol addiction		2.9 (n = 1)		
Sexual dysfunction	4.9 (n = 37)	11.7 (n = 4)		
Violence or abuse in the family	8.5 (n = 65)	5.8 (n = 2)		
Criminal behavior	2.5 (n = 19)			
Suicide attempts	6.1 (n = 47)	5.8 (n = 2)		
Mental subnormality	0.7 (n = 5)	2.9 (n = 1)		
Severe marital conflict	20.5 (n = 156)	19.8 (n = 7 couples)		

** $p < .01$.

APPENDIX 4.20. AGE DISTRIBUTION OF TREATED SUBJECTS AT REFERRAL

Sample	Under 6	6 - 9.11	10 - 13.11	14 and over	Chi-square	df
% of retrospective sample	23.0 (n = 175)	33.7 (n = 257)	28.9 (n = 221)	14.4 (n = 110)	0.36	3
% of follow-up sample	20.5 (n = 7)	38.2 (n = 13)	26.4 (n = 9)	14.7 (n = 5)		

n.s.

APPENDIX 4.21. DISTRIBUTION OF OVERALL IQ SCORES FOR TREATED SUBJECTS

Intelligence level	% of retrospective sample (n = 763)	% of follow-up sample (n=27)	Chi-square	df
75 or below	1.9 (n = 15)		0.68	4
76-90	6.5 (n = 50)	7.4 (n = 2)		
91-110	31.0 (n = 236)	33.3 (n = 9)		
111-125	36.3 (n = 277)	33.3 (n = 9)		
126 or above	24.3 (n = 185)	25.9 (n = 7)		

n.s.

APPENDIX 4.22. PRINCIPAL PSYCHIATRIC DIAGNOSES OF CHILDREN REFERRED FOR TREATMENT

Diagnostic category	% in retrospective sample (n = 763)*	% in follow-up sample (n = 34)	Chi-square	df
Anxiety disorders	25.4 (n = 194)	47.0 (n = 16)	149.45**	8
Depressive disorders	10.5 (n = 80)	5.8 (n = 2)		
Disruptive disorders (Conduct and ADHD)	11.3 (n = 86)	5.8 (n = 2)		
Pervasive developmental disorders and psychoses	4.3 (n = 33)	11.7 (n = 4)		
Enuresis	4.8 (n = 37)			
Encopresis	2.5 (n = 19)	2.9 (n = 1)		
Other specific childhood disorders (developmental, tics, mutism)	4.5 (n = 46)	14.7 (n = 5)		
Personality, attachment and stress disorders	3.2 (n = 24)	2.9 (n = 1)		
No diagnosis	7.3 (n = 56)	8.8 (n = 3)		
Insufficient information	7.3 (n = 56)			

** $p < .01$.

* Frequencies regarding the full retrospective sample (Target, 1993) add up to 82.6%.

APPENDIX 4.23. FREQUENCIES OF SCHOOL DIFFICULTIES

Type of difficulty	% of retrospective sample (n = 763)	% of follow-up sample (n = 34)	Chi-square	df
School refusal	7.0 (n = 53)	2.9 (n = 1)	59.55**	6
Disabling anxiety	4.0 (n = 30)	5.8 (n = 2)		
Specific learning disability	14.2 (n = 108)	20.5 (n = 7)		
Underachievement	26.0 (n = 198)	26.4 (n = 9)		
Poor peer relations	15.5 (n = 118)	11.7 (n = 4)		
Disruptive behavior	10.0 (n = 76)	5.8 (n = 2)		
Other	2.0 (n = 15)	14.7 (n = 5)		

** $p < .01$.

APPENDIX 4.24. THE DISTRIBUTION OF ASSESSMENT HCAM SCORES IN THE FOLLOW-UP AND FULL RETROSPECTIVE SAMPLES

Level of HCAM score	% of retrospective sample (n = 763)	% of follow-up sample (n = 34)	Chi-square	df
Below 40 (severe, disabling symptoms)	1.3 (n = 10)		8.67	5
40-49 (moderate, widespread impairment)	20.0 (n = 153)	11.7 (n = 4)		
50-59 (several areas impaired)	39.8 (n = 304)	61.7 (n = 21)		
60-69 (single area of difficulty)	31.5 (n = 240)	20.5 (n = 7)		
70-79 (minimal impairment)	6.5 (n = 49)	2.9 (n = 1)		
80-89 (good functioning in all areas)	0.9 (n = 7)	2.9 (n = 1)		

n.s.

APPENDIX 4.25. FREQUENCY OF TREATMENT SESSIONS PER WEEK IN FOLLOW-UP AND RETROSPECTIVE SAMPLES

Number of weekly sessions	% of retrospective sample	% of follow-up sample	Chi-square	df
1-3 sessions	23.3 (n = 178)	23.5 (n = 8)	0.00	1
4-5 sessions	76.6 (n = 585)	76.4 (n = 26)		

n.s.

APPENDIX 4.26. DISTRIBUTION OF LENGTH OF TREATMENT

Length of treatment	% of retrospective sample (n = 763)	% of follow-up sample (n = 34)	Chi-square	df
Under 1 year	29.2 (n = 223)	2.8 (n = 1)	16.04*	3
1-3 years	48.2 (n = 368)	55.8 (n = 19)		
3-5 years	15.7 (n = 120)	35.2 (n = 12)		
Over 5 years	6.9 (n = 53)	5.8 (n = 2)		

* $p < .05$.

APPENDIX 5.1. THE HOPE-GOLDTHORPE OCCUPATION RATINGS SCALE

Rating

1. Self-employed Professionals
(Doctors; lawyers; accountants; dentists; surveyors; architects; pharmacists; engineers; stock and insurance brokers.)

2. Salaried Professionals: higher grade
(Engineers; accountants and company secretaries; surveyors; doctors; natural scientists; architects and town planners; university teachers; lawyers; airline pilots.)

3. Administrators and Officials: higher grade
(Managers in large commercial enterprises and public utilities; sales managers; senior civil servants; local authority senior officers; also includes company directors, n.e.c.)

4. Industrial Managers: large enterprises
(Managers in engineering, extractive industries, general manufacturing and construction; personnel managers in all large establishments.)

5. Administrators and Officials: lower grade
(Police officers; radio and telegraph officers.)

6. Technicians: higher grade
(Work study engineers; computer programmers; draughtsmen; laboratory technicians.)

7. Large Proprietors
(Working owners of large shops and service agencies.)

8. Industrial and Business Managers: small enterprises
(Managers in commerce, public utilities, engineering, extractive industries, general manufacturing and construction; personnel managers in all small establishments.)

9. Self-employed Professionals: lower grade
(Parochial clergy; entertainers; artists; journalists.)

10. Salaried Professionals: lower grade
(Primary and secondary school teachers; civil service executive officers; social welfare workers; nurses; public health inspectors; journalists; commercial artists; translators.)

11. Farmers and Farm Managers

12. Supervisors of Non-Manual Employees: higher grade
(Supervisors of clerical employees.)

13. Small Proprietors
(Working owners of small shops and service agencies; small builders; painters and decorators; hoteliers; boarding-house keepers and restauranteurs.)

14. Managers in Services and Small Administrative Units
(Managers of shops and service agencies; office managers; hotel and restaurant managers.)

15. Technicians: lower grade
(Electrical and electronic engineers; Post Office technicians; auto-engineers; radio engineers; fire brigade men.)

16. Supervisors of Non-Manual Employees: lower grade

17. Supervisors of Manual Employees: higher grade
(Foremen in engineering, construction, communications and mining.)

18. Skilled Manual Workers in Manufacturing: higher grade
(Maintenance and other fitters; millwrights; toolmakers; pattern-makers.)

19. Self-employed Workers: higher grade
(Shopkeepers; painters and decorators; carpenters and joiners; jobbing builders; publicans.)

20. Supervisors of Manual Employees: lower grade
(Foremen in warehousing, distribution, transport, chemicals and food products.)

21. Non-Manual Employees in Administration and Commerce
(Clerical workers; cashiers; commercial travellers; hotel receptionists; advice workers; bank note valuers and dealers.)

22. Skilled Manual Workers in Manufacturing: intermediate grade
(Machine setters; sheetmetal workers; precision instrument makers; printers and compositors; glass and ceramic formers; also includes 'other ranks' in the Armed Services.)

23. Skilled Manual Workers in Construction
(Carpenters and joiners; painters and decorators; bricklayers.)

24. Smallholders without Employees

25. Service Workers: higher grade

26. Semi-skilled Manual Workers in Manufacturing
(Machine-tool operators; press operators; assemblers and routine inspectors; chemical process workers; food and other process workers.)

27. Skilled Manual Workers in Transport, Communications and Services, and Extractive Industries
(Coalminers; operators of cranes and earth-moving equipment; engine drivers; steel erectors and riggers; motor mechanics.)

28. Service workers: intermediate grade
(Shop salesmen and assistants; play group assistants who have been on training courses; youth workers (unqualified); naval photographers.)

29. Self-employed Workers: intermediate grade
(Taxi drivers; carriers; cafe owners; entertainers.)

30. Skilled Manual Workers in Manufacturing: lower grade
(Plant and engine operators; locksmiths, engravers and other metal-working craftsmen; moulders, furnacemen and forgemen; sawyers and woodworkers; butchers; bakers.)

31. Agricultural Workers

32. Semi-skilled Manual Workers in Construction and Extractive Industries
(Roofers, asphalters and cable layers; demolition workers; surface workers in mining and quarrying.)

33. Semi-skilled Manual Workers in Transport, Communications and Services
(Lorry drivers; warehousemen; packers and labellers; storekeepers; postal workers; bus and coach drivers; roundsmen; ambulancemen; deckhands; railway lengthmen; dock workers; gardeners and groundsmen; dry-cleaners and pressers; play group leaders - no training course; care assistants.)

34. Service Workers: lower grade
(Caretakers; doormen; guards and attendants; telephone operators; waiters; barmen and counterhands; school laboratory assistants.)

35. Unskilled Manual Workers
(General labourers; factory labourers; building site labourers; railway porters; kitchen porters; office and industrial cleaners; messengers.)

36. Self-employed Workers: lower grade
(Street vendors; jobbing gardeners.)

37. Unemployment

38. Criminal Class - prostitution, drug dealing, selling stolen goods

39. charity work

Westenv2rater(1)

Correlations between sort for this subject and PD norms

Corr. R1	0.193	0.341	0.386	0.066	0.254	0.068	-0.017	0.331	0.115	0.019	-0.199
Corr. R2	0.249	0.296	0.450	0.054	0.338	0.235	0.044	0.285	0.148	0.018	-0.208
Corr. Av	**0.235**	**0.339**	**0.444**	**0.064**	**0.315**	**0.161**	**0.015**	**0.328**	**0.140**	**0.020**	**-0.216**

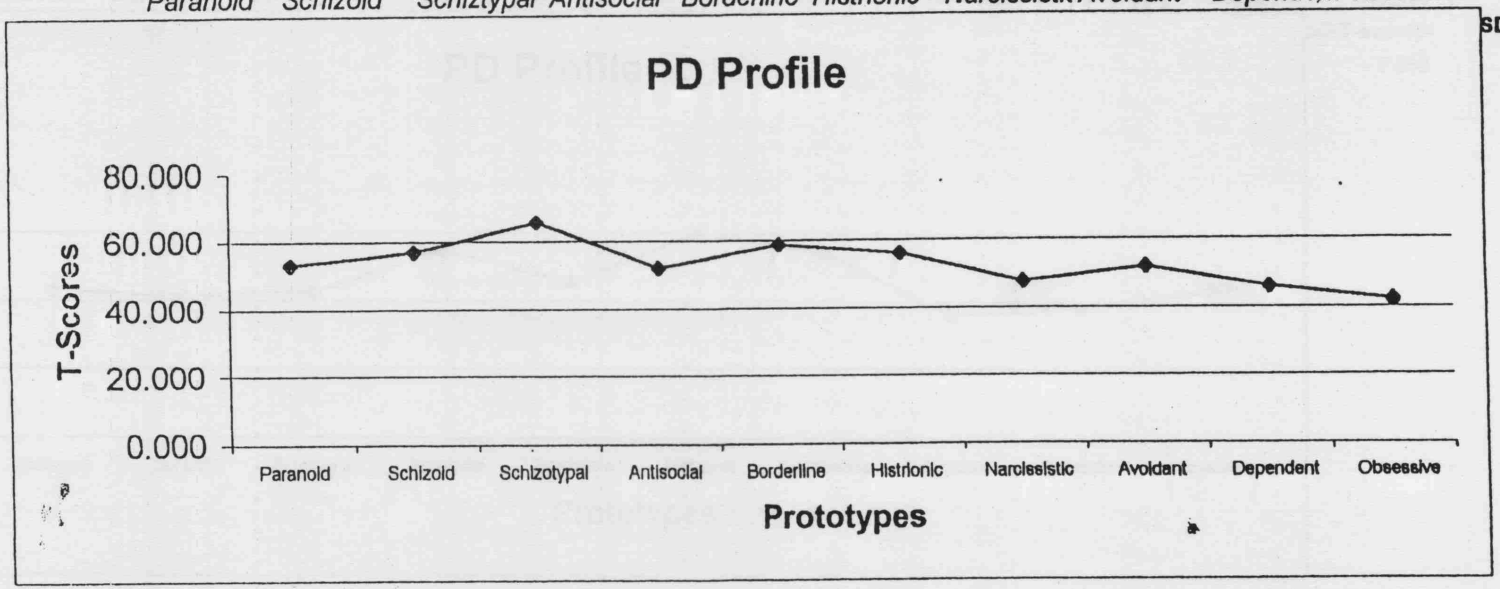
ability (200) = 0.769

Agreement between raters in their correlations with PD Profile and T-scores

liability (11)= 0.940 **HI-fx= -0.216** **verage Corr= 0.206** **SD(corr)= 0.149** **Normality1= -1.414** **Normality2= -1.000**

	Paranoid	Schizoid	Schiztypal	Antisocial	Borderline	Histrionic	Narcissistic	Avoidant	Dependent	Obsessive	
T-scores	**52.972**	**56.749**	**65.520**	**51.785**	**58.451**	**55.723**	**47.367**	**51.551**	**45.551**	**41.719**	**Average T= 52.739**

SD(T-score)= 6.874



Westenv2rater(1)

Correlations between sort for this subject and PD norms

Corr. R1	0.015	-0.035	-0.045	0.186	0.037	0.203	0.177	-0.099	-0.076	0.031	0.316
Corr. R2	0.034	-0.056	-0.088	0.093	0.113	0.252	0.156	-0.033	0.038	0.073	0.377
Corr. Av	**0.025**	**-0.048**	**-0.070**	**0.147**	**0.079**	**0.239**	**0.175**	**-0.069**	**-0.020**	**0.055**	**0.365**

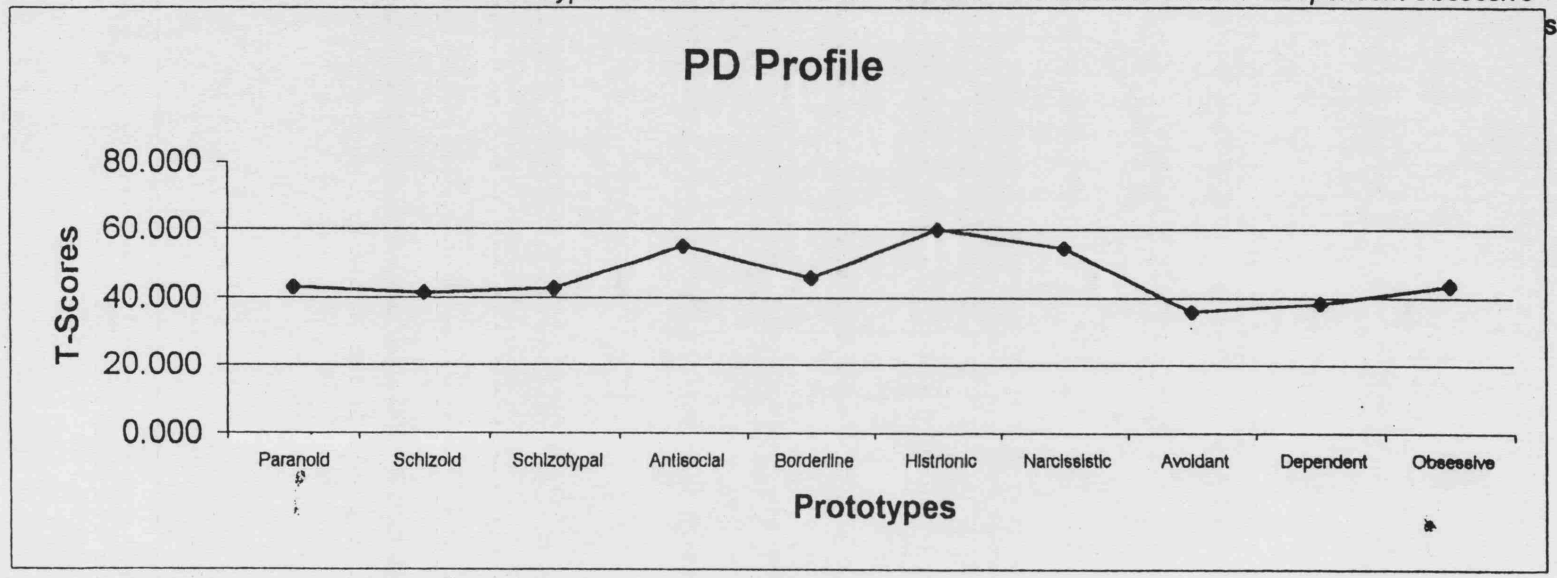
Reliability (200) = 0.810

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (11)= 0.900 **HI-fx= 0.365** **verage Corr= 0.051** **SD(corr)= 0.108** **Normality1= 0.851** **Normality2= 0.138**

T-scores	**42.900**	**41.294**	**42.659**	**54.738**	**45.424**	**59.708**	**54.164**	**35.609**	**38.214**	**43.433**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**45.814**

SD(T-score)= 7.810



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Westenv2rater(1)

Correlations between sort for this subject and PD norms

Corr. R1	0.038	0.097	-0.064	-0.154	-0.219	-0.276	-0.047	0.181	-0.019	0.368	0.617
Corr. R2	-0.061	0.048	-0.171	-0.210	-0.207	-0.275	-0.062	0.215	0.063	0.403	0.736
Corr. Av	**-0.012**	**0.078**	**-0.126**	**-0.195**	**-0.229**	**-0.295**	**-0.058**	**0.212**	**0.023**	**0.413**	**0.726**

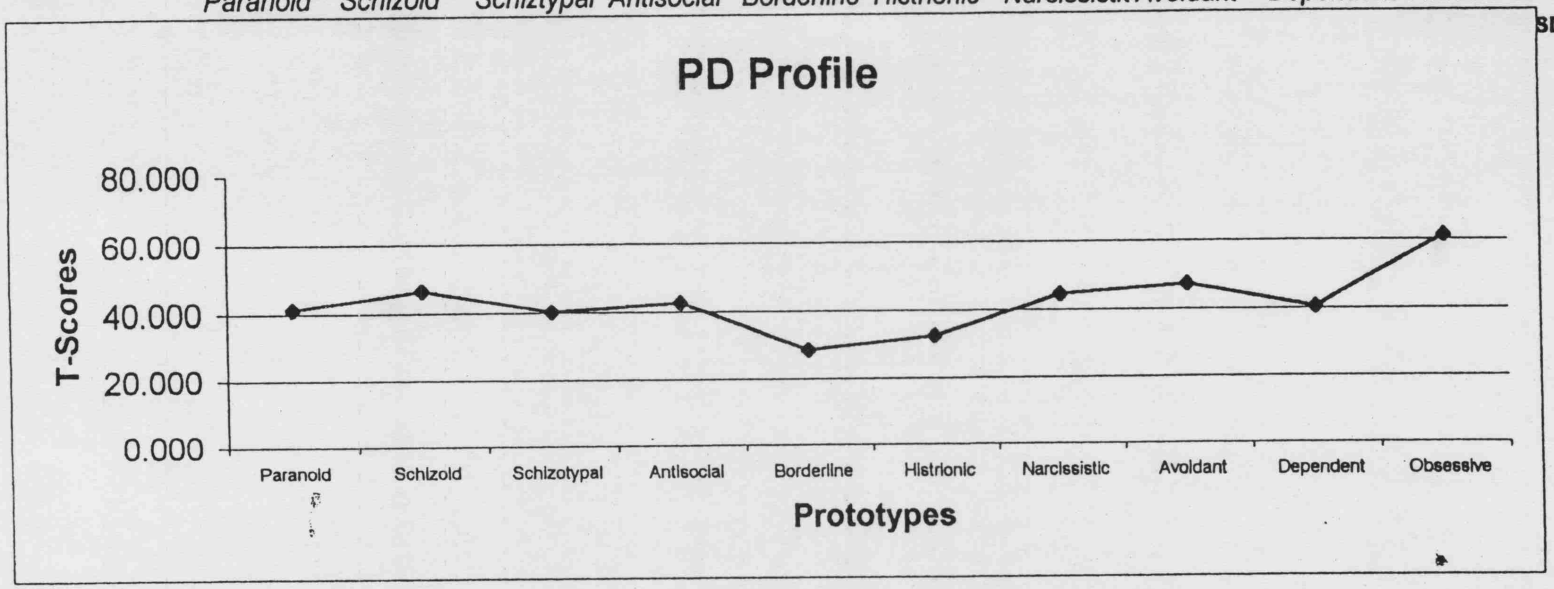
Reliability (200) = 0.739

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (11)= 0.980 **Hi-fx= 0.726** **verage Corr= -0.019** **SD(corr)= 0.215** **Normality1= 1.026** **Normality2= 0.662**

T-scores	**41.086**	**46.320**	**40.184**	**42.543**	**28.423**	**32.426**	**44.262**	**46.926**	**40.194**	**61.105**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**42.347**

SD(T-score)= 8.791



Westenv2rater(1)

Correlations between sort for this subject and PD norms

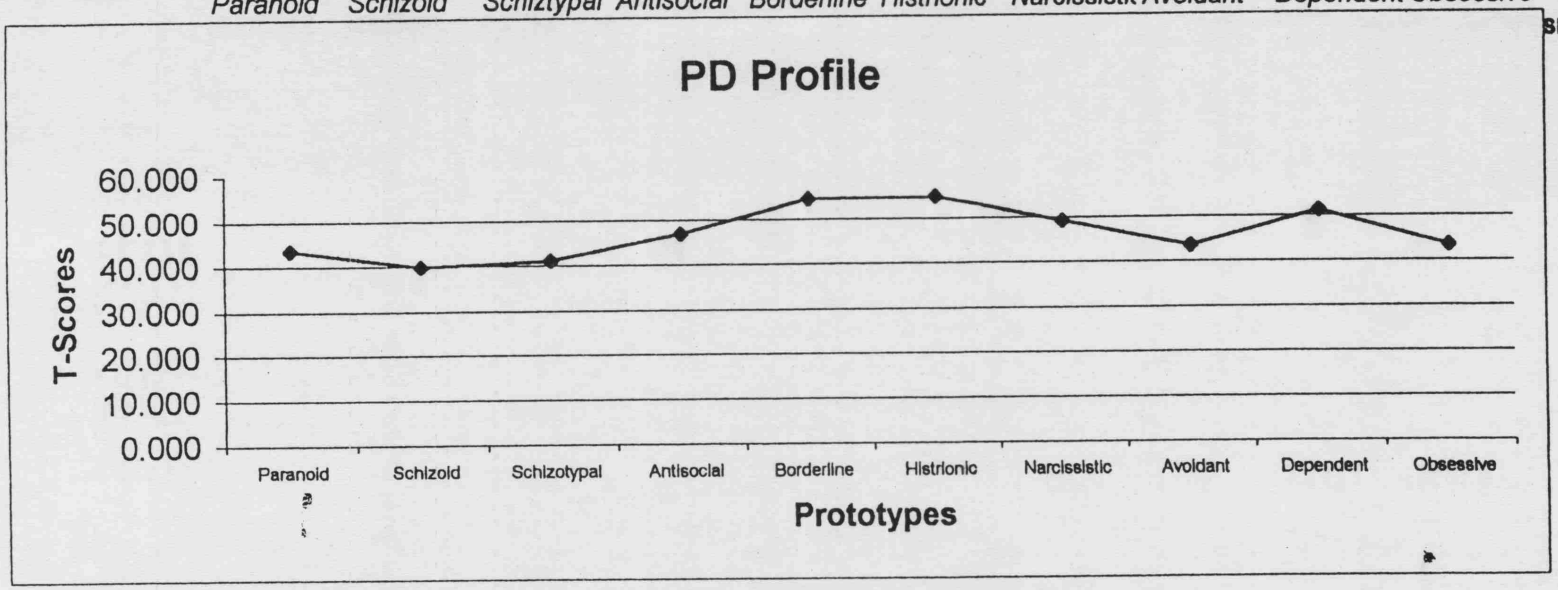
Corr. R1	0.011	-0.068	-0.108	-0.103	0.235	0.104	0.001	0.143	0.266	0.096	0.455
Corr. R2	0.058	-0.101	-0.099	-0.039	0.232	0.166	0.104	0.094	0.238	0.003	0.401
Corr. Av	**0.036**	**-0.088**	**-0.107**	**-0.073**	**0.242**	**0.140**	**0.055**	**0.123**	**0.261**	**0.051**	**0.444**

Reliability (200) = 0.859

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (11)= 0.939 **Hi-fx= 0.444** **verage Corr= 0.064** **SD(corr)= 0.130** **Normality1= 0.847** **Normality2= 0.190**

T-scores	**43.424**	**39.698**	**41.002**	**46.881**	**54.433**	**54.650**	**49.060**	**43.323**	**51.117**	**43.253**	**Average T= 46.684**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 5.412**



Westenv2rater(1)

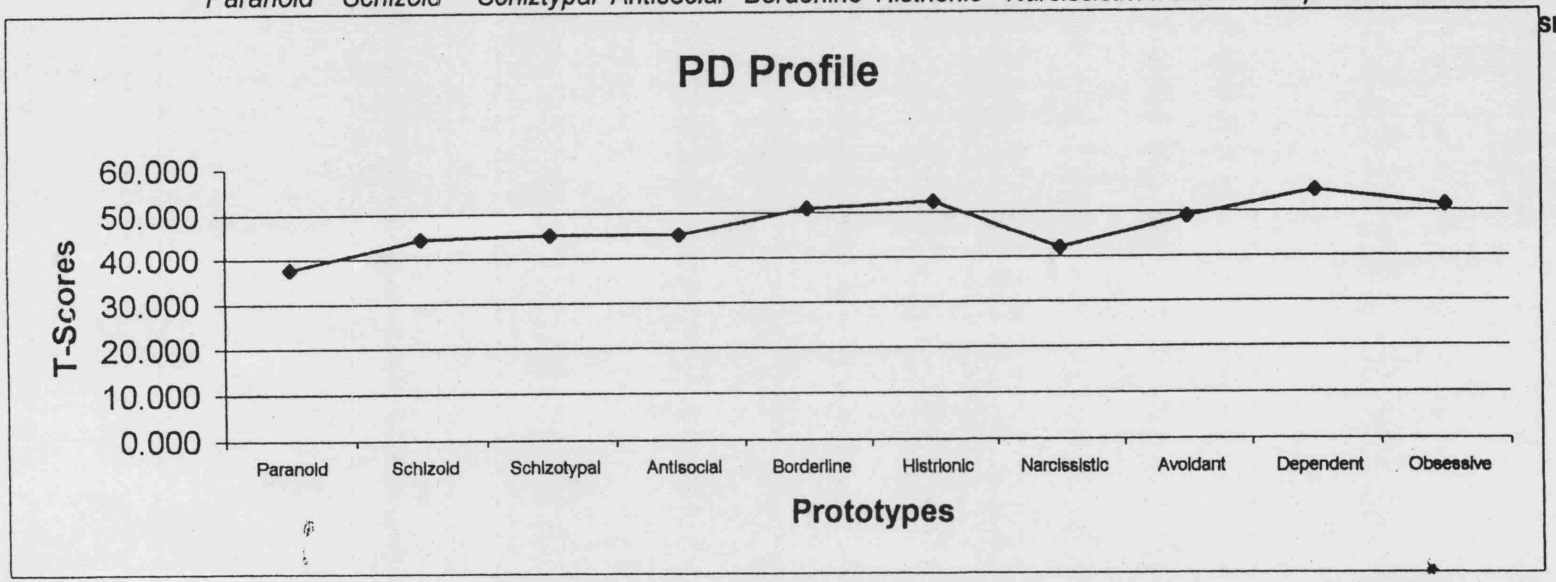
Corr. R1	-0.077	-0.021	-0.048	-0.106	0.171	0.101	-0.080	0.224	0.282	0.177	0.390
Corr. R2	-0.091	0.080	0.025	-0.120	0.166	0.077	-0.136	0.273	0.355	0.228	0.331
Corr. Av	**-0.088**	**0.031**	**-0.012**	**-0.118**	**0.177**	**0.093**	**-0.113**	**0.260**	**0.333**	**0.212**	**0.377**

Reliability (200) = 0.831 **Agreement between raters in their correlations with PD Profile and T-scores**

Reliability (11)= 0.950 **HI-fx= 0.377** **verage Corr= 0.077** **SD(corr)= 0.163** **Normality1= 0.778** **Normality2= -0.276**

T-scores	**37.458**	**44.434**	**45.259**	**45.293**	**50.803**	**52.231**	**41.942**	**48.834**	**54.402**	**51.177**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**47.183**

SD(T-score)= 5.231



009c

Westenv2rater(1)

Correlations between sort for this subject and PD norms

Corr. R1	-0.045	-0.183	-0.264	-0.081	-0.142	-0.192	-0.005	-0.026	-0.038	0.159	0.759
Corr. R2	-0.004	-0.157	-0.239	-0.093	-0.038	-0.148	-0.016	0.041	0.086	0.254	0.699
Corr. Av	**-0.026**	**-0.178**	**-0.264**	**-0.091**	**-0.094**	**-0.178**	**-0.011**	**0.008**	**0.025**	**0.216**	**0.763**

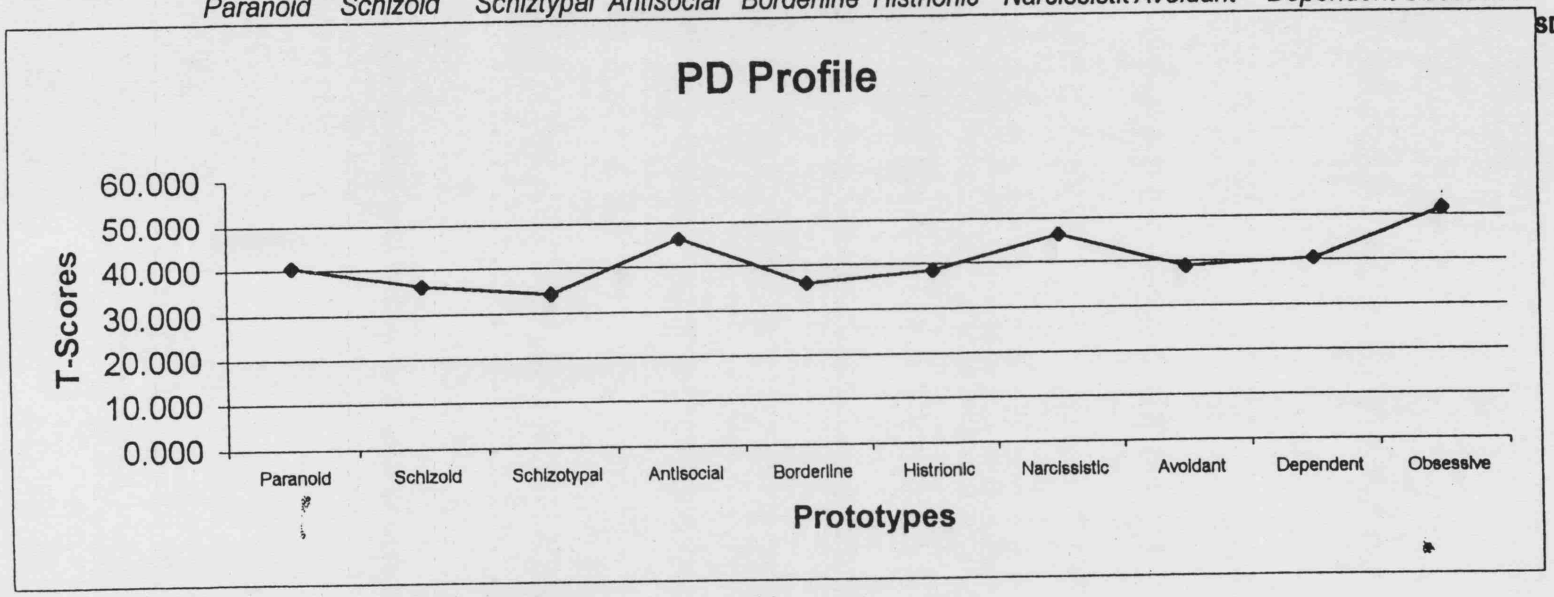
Agreement between raters in their correlations with PD Profile and T-scores

Reliability (200) = 0.825

Reliability (11)= 0.982 **Hi-fx= 0.763** **verage Corr= -0.059** **SD(corr)= 0.134** **Normality1= 1.074** **Normality2= 0.933**

T-scores	**40.450**	**36.086**	**34.065**	**46.257**	**35.856**	**38.435**	**46.272**	**38.703**	**40.261**	**51.380**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**40.777**

SD(T-score)= 5.518



11c

Correlations between sort for this subject and PD norms

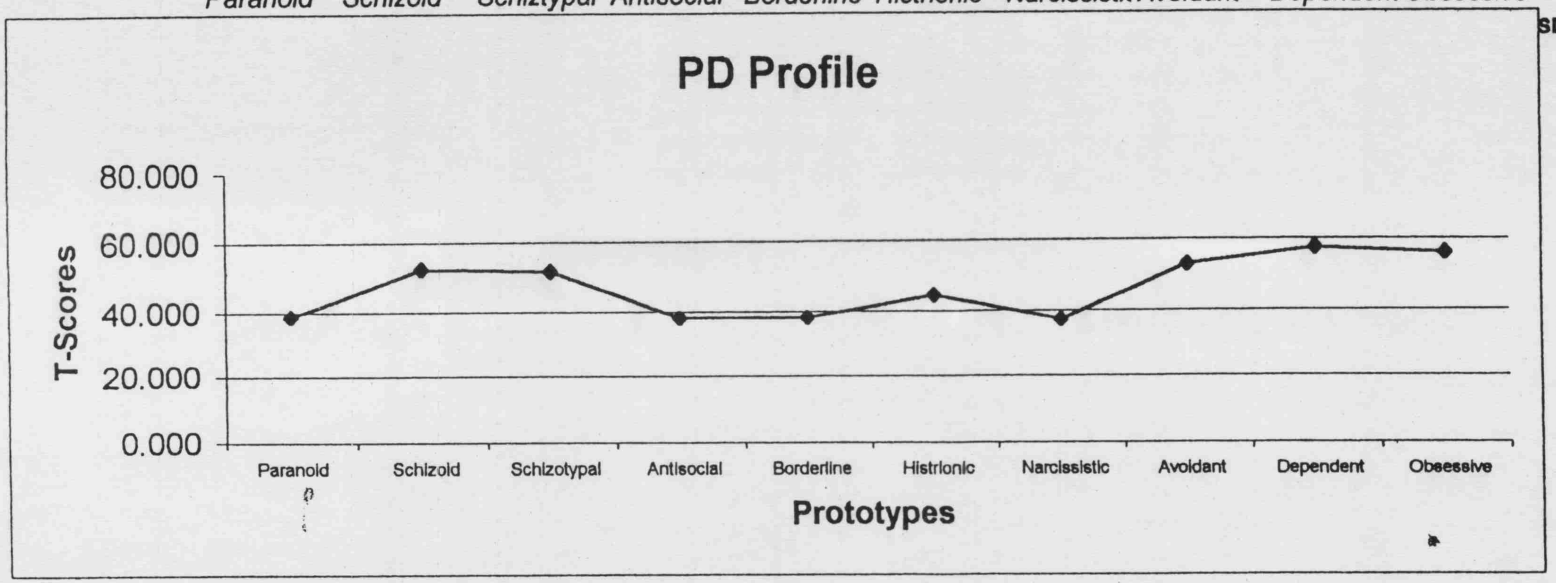
Corr. R1	-0.051	0.229	0.135	-0.286	-0.131	-0.093	-0.206	0.317	0.306	0.268	0.379
Corr. R2	-0.066	0.190	0.104	-0.300	0.031	-0.020	-0.201	0.345	0.423	0.294	0.365
Corr. Av	**-0.064**	**0.229**	**0.131**	**-0.320**	**-0.055**	**-0.062**	**-0.222**	**0.362**	**0.398**	**0.307**	**0.406**

Reliability (200) = 0.676

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (11)= 0.964 **Hi-fx= 0.406** **verage Corr= 0.070** **SD(corr)= 0.251** **Normality1= 0.815** **Normality2= -0.224**

T-scores	**38.615**	**52.360**	**51.592**	**38.074**	**38.025**	**44.350**	**37.323**	**52.918**	**57.386**	**55.871**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**46.651**
											SD(T-score)=
											8.174



Westenv2rater(1)

Correlations between sort for this subject and PD norms

Corr. R1	-0.002	0.074	-0.045	-0.023	-0.089	-0.052	-0.009	0.145	0.075	0.063	0.478
Corr. R2	-0.180	-0.002	-0.103	-0.156	-0.108	-0.018	-0.098	0.147	0.177	0.077	0.582
Corr. Av	**-0.099**	**0.039**	**-0.080**	**-0.097**	**-0.106**	**-0.038**	**-0.058**	**0.158**	**0.136**	**0.076**	**0.573**

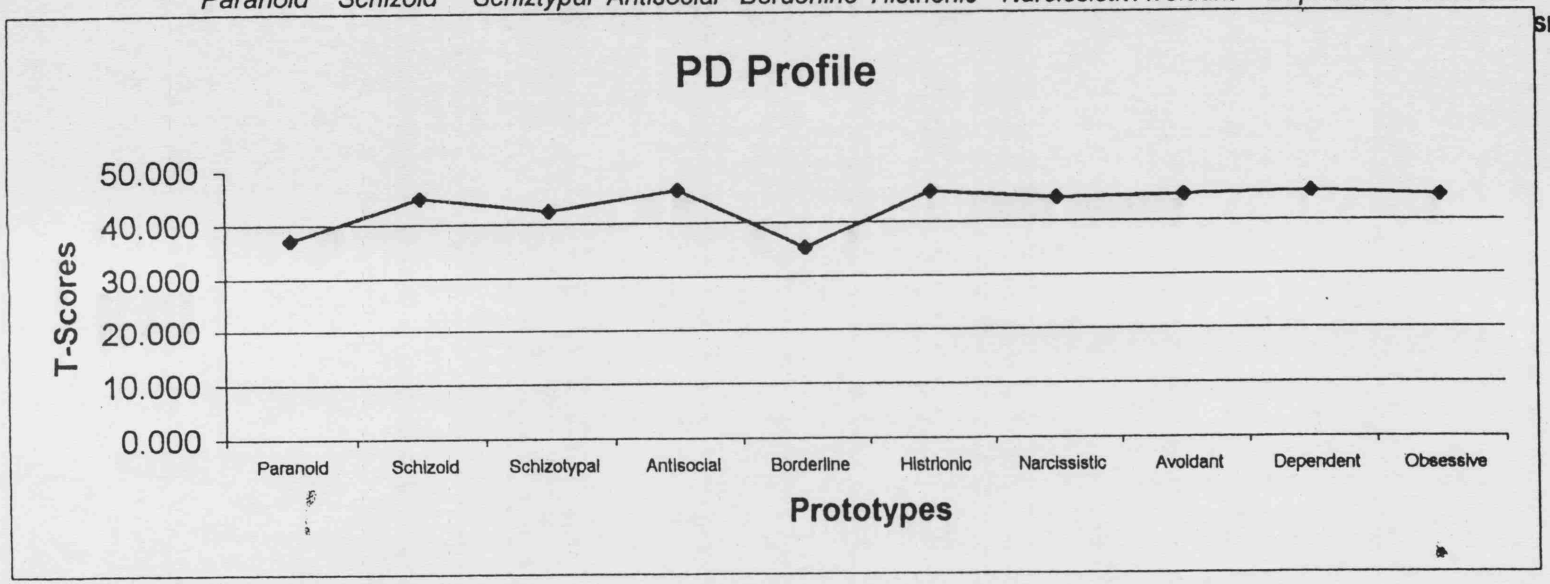
Reliability (200) = 0.708

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (11)= 0.938 **Hi-fx= 0.573** **verage Corr= -0.007** **SD(corr)= 0.101** **Normality1= 1.012** **Normality2= 0.855**

T-scores	**36.937**	**44.771**	**42.214**	**46.035**	**35.178**	**45.553**	**44.272**	**44.736**	**45.388**	**44.473**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**42.955**

SD(T-score)= 3.799



706

Correlations between sort for this subject and PD norms

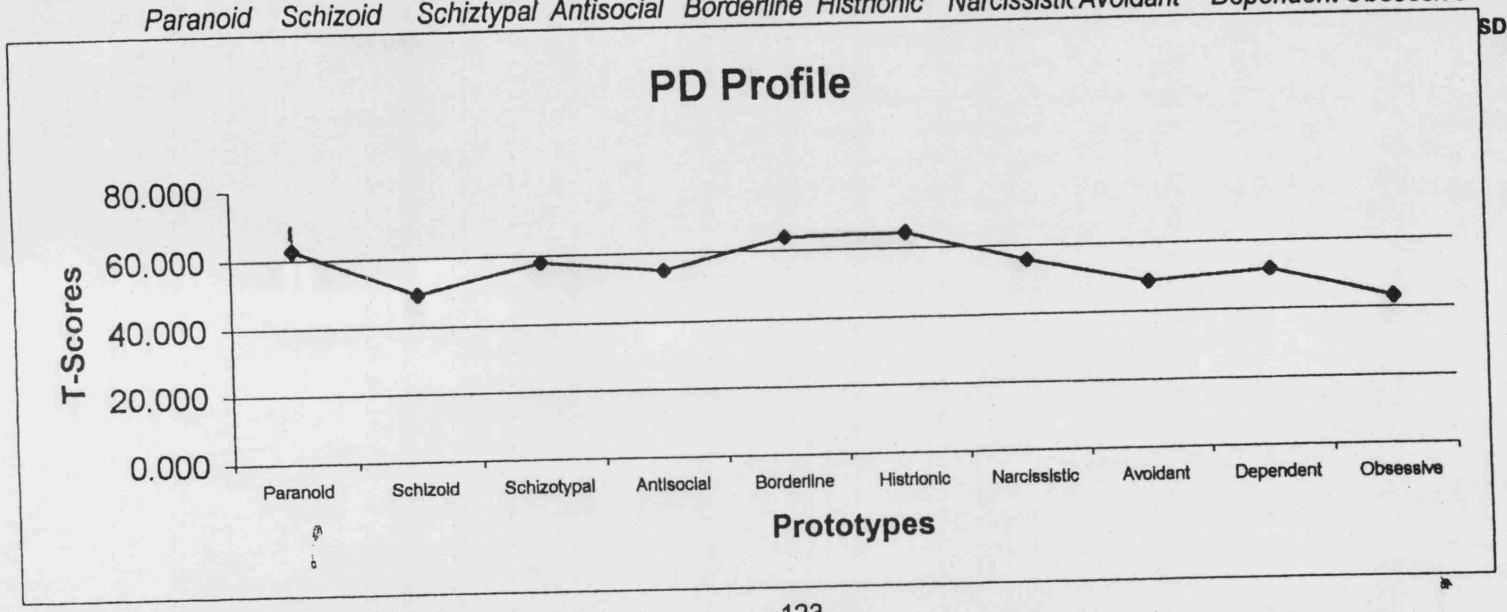
Corr. R1	0.342	0.079	0.179	0.105	0.420	0.334	0.144	0.188	0.249	0.011	-0.125
Corr. R2	0.455	0.201	0.315	0.168	0.328	0.267	0.232	0.271	0.240	0.074	-0.178
Corr. Av	0.437	0.154	0.271	0.150	0.411	0.330	0.206	0.251	0.269	0.046	-0.166

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.661 | liability (11)= 0.871 | Hi-fx= -0.166 | verage Corr= 0.253 | SD(corr)= 0.120 | Normality1= -4.831 | Normality2= -1.000

T-scores	**62.708**	**49.355**	**57.820**	**54.858**	**63.738**	**64.329**	**55.475**	**48.494**	**51.453**	**43.018**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**55.125**

SD(T-score)= 7.159

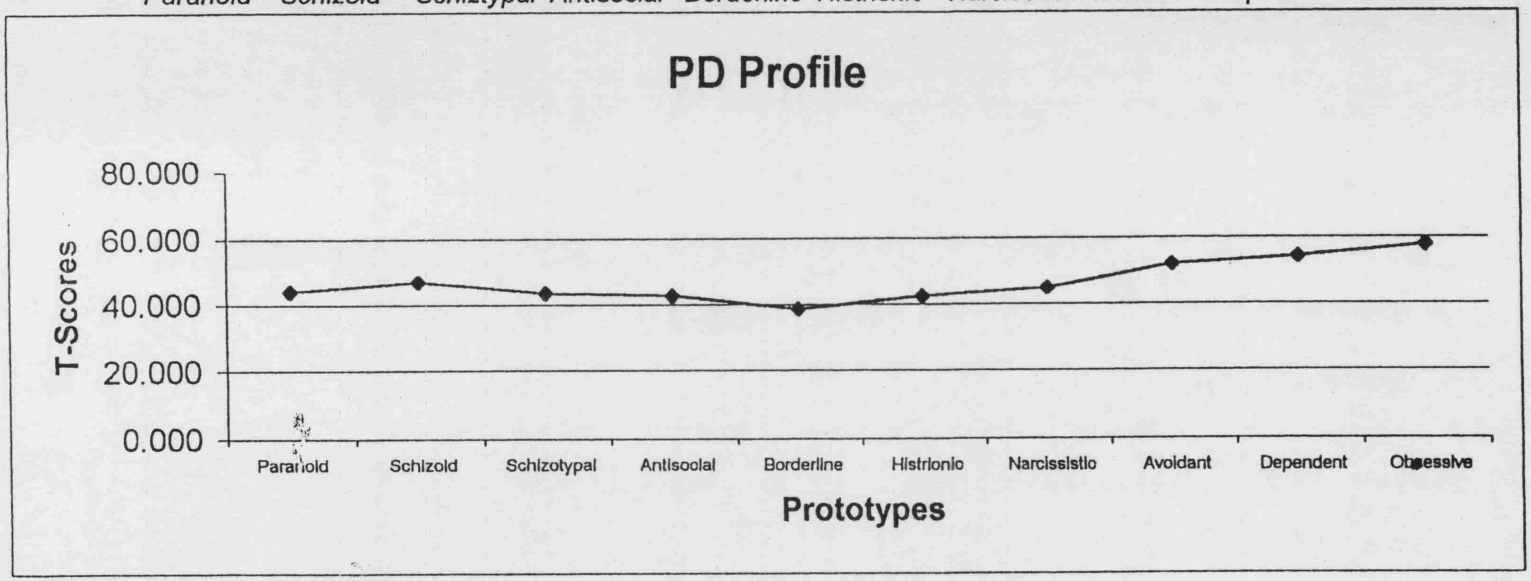


Correlations between sort for this subject and PD norms

Corr. R1	-0.001	0.101	-0.023	-0.215	0.002	-0.078	-0.076	0.351	0.327	0.277	0.544
Corr. R2	-0.063	0.096	-0.048	-0.278	-0.079	-0.179	-0.141	0.307	0.279	0.349	0.617
Corr. R3	0.081	0.065	-0.081	-0.146	-0.090	-0.113	-0.011	0.273	0.287	0.364	0.507
Corr. Av	**0.043**	**0.089**	**-0.055**	**-0.194**	**-0.047**	**-0.102**	**-0.047**	**0.335**	**0.329**	**0.343**	**0.563**

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (2(	R1vR2= 0.780		R1vR3= 0.740		R2vR3= 0.725		Mean= 0.749				
Reliability (1'	R1vR2= 0.989		R1vR3= 0.956		R2vR3= 0.968		Mean= 0.971		HI-fx=	0.563	
Average Cori	0.069	SD(corr)=	0.199	Normality1=	0.870	Normality2=	0.049	Average T=	46.558	SD (Tscore)=	6.068
T-scores	**43.759**	**46.767**	**43.313**	**42.581**	**38.431**	**42.284**	**44.746**	**51.837**	**54.209**	**57.657**	
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	*Hi-Fx*



Westenv2rater

Correlations between sort for this subject and PD norms

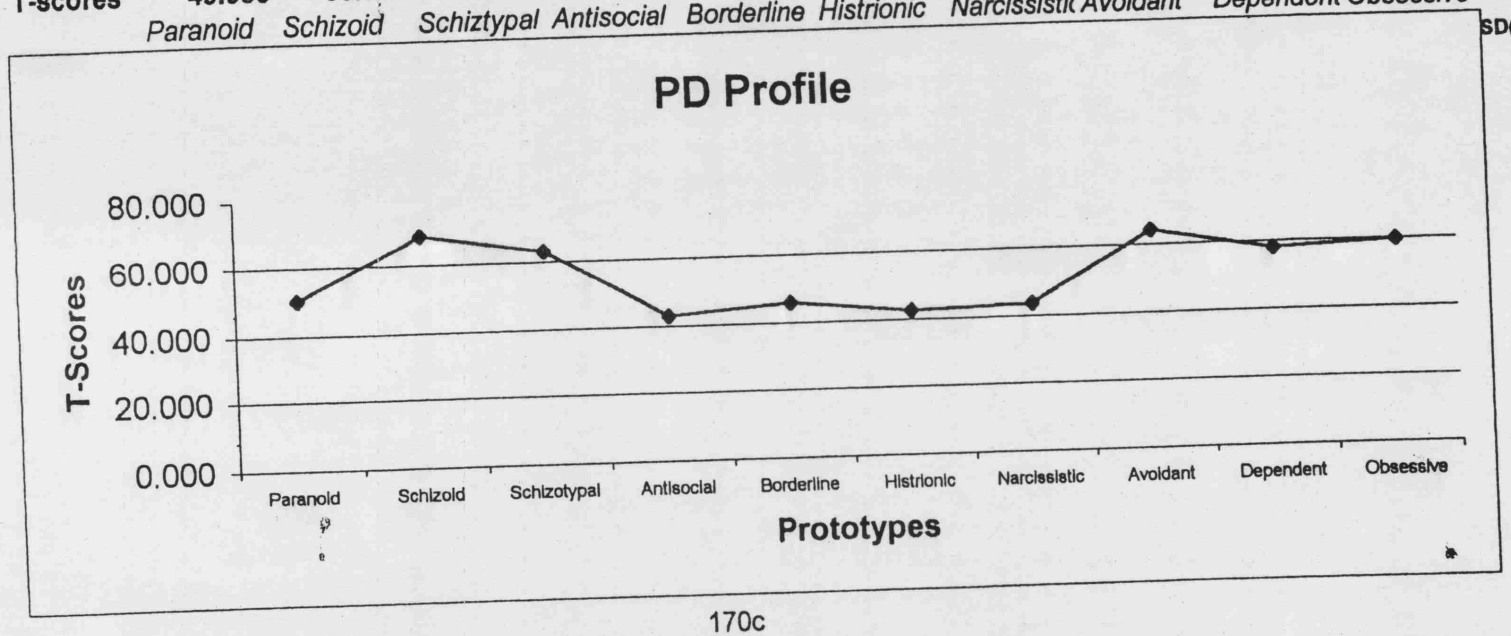
Corr. R1	0.215	0.625	0.393	-0.152	0.119	-0.106	-0.087	0.619	0.389	0.359	0.107
Corr. R2	0.119	0.604	0.358	-0.211	0.044	-0.088	-0.069	0.610	0.402	0.380	0.202
Corr. Av	**0.173**	**0.635**	**0.388**	**-0.188**	**0.084**	**-0.100**	**-0.080**	**0.635**	**0.409**	**0.382**	**0.160**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.872

liability (11)= 0.981 **Hi-fx= 0.160** **verage Corr= 0.234** **SD(corr)= 0.300** **Normality1= -0.261** **Normality2= -0.939**

T-scores	**49.980**	**68.610**	**63.035**	**42.795**	**45.710**	**42.393**	**43.331**	**63.899**	**57.872**	**59.558**	**Average T= 53.718**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 9.984**



170c

709

Correlations between sort for this subject and PD norms

Corr. R1	-0.074	0.030	-0.061	-0.189	-0.177	-0.212	-0.205	0.103	0.074	0.228	0.542
Corr. R2	-0.066	0.119	0.028	-0.195	-0.090	-0.108	-0.146	0.231	0.179	0.238	0.490
Corr. Av	**-0.075**	**0.080**	**-0.018**	**-0.206**	**-0.143**	**-0.171**	**-0.188**	**0.179**	**0.135**	**0.249**	**0.552**

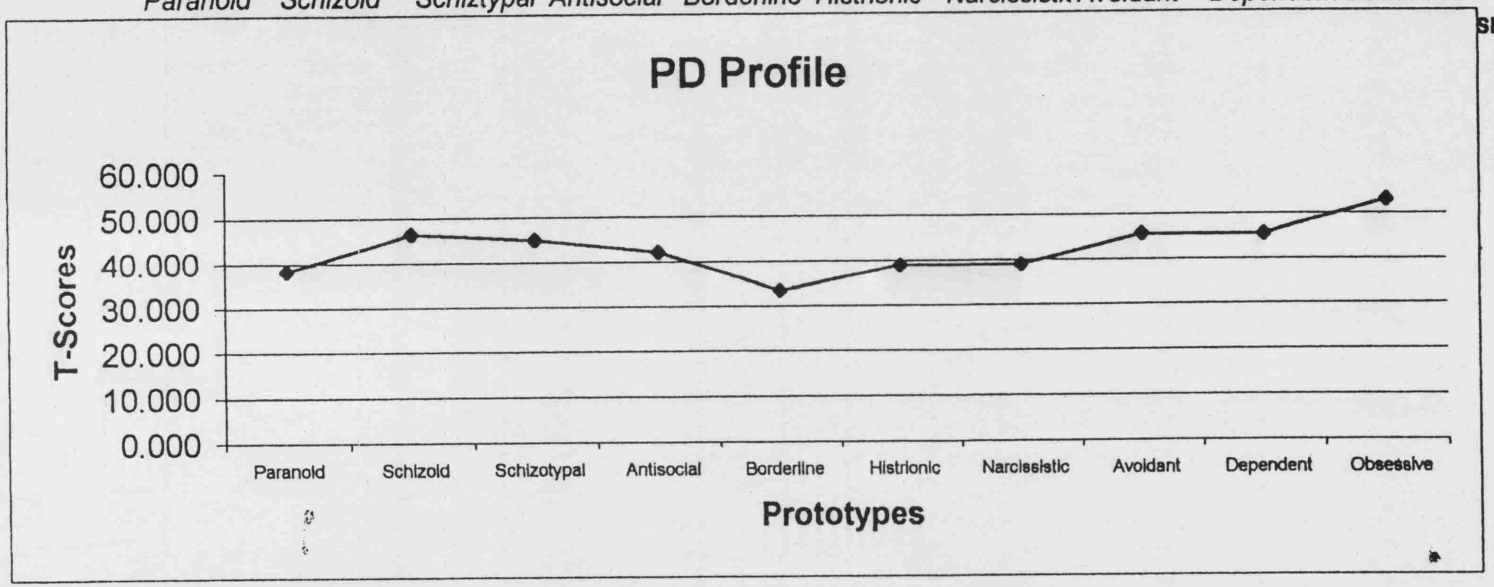
ability (200) = 0.749

Agreement between raters in their correlations with PD Profile and T-scores

liability (11)= 0.970 **Hi-fx= 0.552** **verage Corr= -0.016** **SD(corr)= 0.166** **Normality1= 1.028** **Normality2= 0.704**

T-scores	**38.090**	**46.391**	**44.984**	**42.153**	**33.152**	**38.758**	**38.783**	**45.575**	**45.337**	**52.996**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**42.622**

SD(T-score)= 5.613



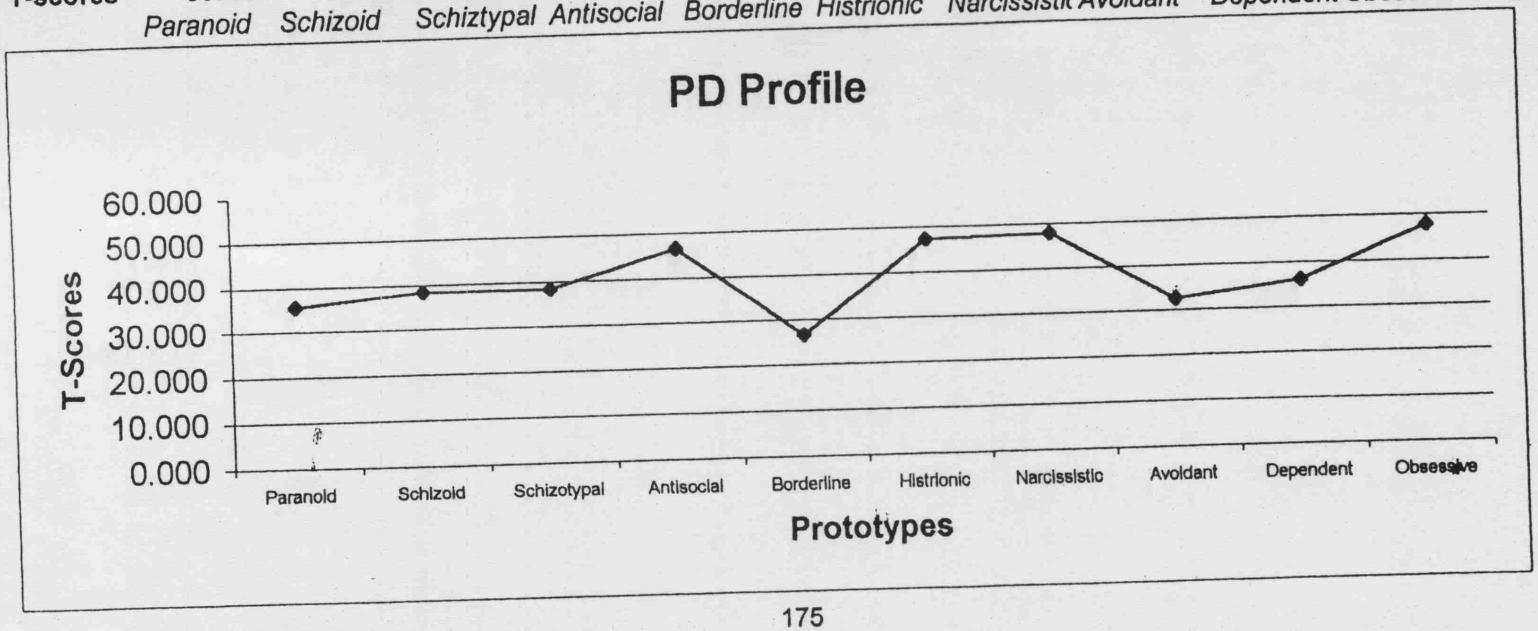
Correlations between sort for this subject and PD norms

Corr. R1	-0.166	-0.259	-0.291	-0.049	-0.240	0.026	0.049	-0.185	-0.094	0.060	0.716
Corr. R2	-0.068	-0.123	-0.143	0.042	-0.169	0.080	0.122	-0.230	-0.155	0.035	0.554
Corr. R3	-0.072	0.029	-0.019	-0.098	-0.239	-0.039	-0.007	-0.085	-0.027	0.198	0.524
Corr. Av	**-0.130**	**-0.126**	**-0.169**	**-0.080**	**-0.262**	**-0.007**	**0.023**	**-0.148**	**-0.066**	**0.141**	**0.677**

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (2(	R1vR2= 0.726		R1vR3= 0.675		R2vR3= 0.749		Mean= 0.717			
Reliability (1'	R1vR2= 0.957		R1vR3= 0.868		R2vR3= 0.827		Mean= 0.884		HI-fx=	0.677
Average Cori -0.082		SD(corr)= 0.113		Normality1= 1.113		Normality2= 0.967		Average T= 39.619		SD (Tscore)= 7.383

T-scores	**35.449**	**38.167**	**38.274**	**46.644**	**26.599**	**47.128**	**47.709**	**32.458**	**36.087**	**47.672**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*



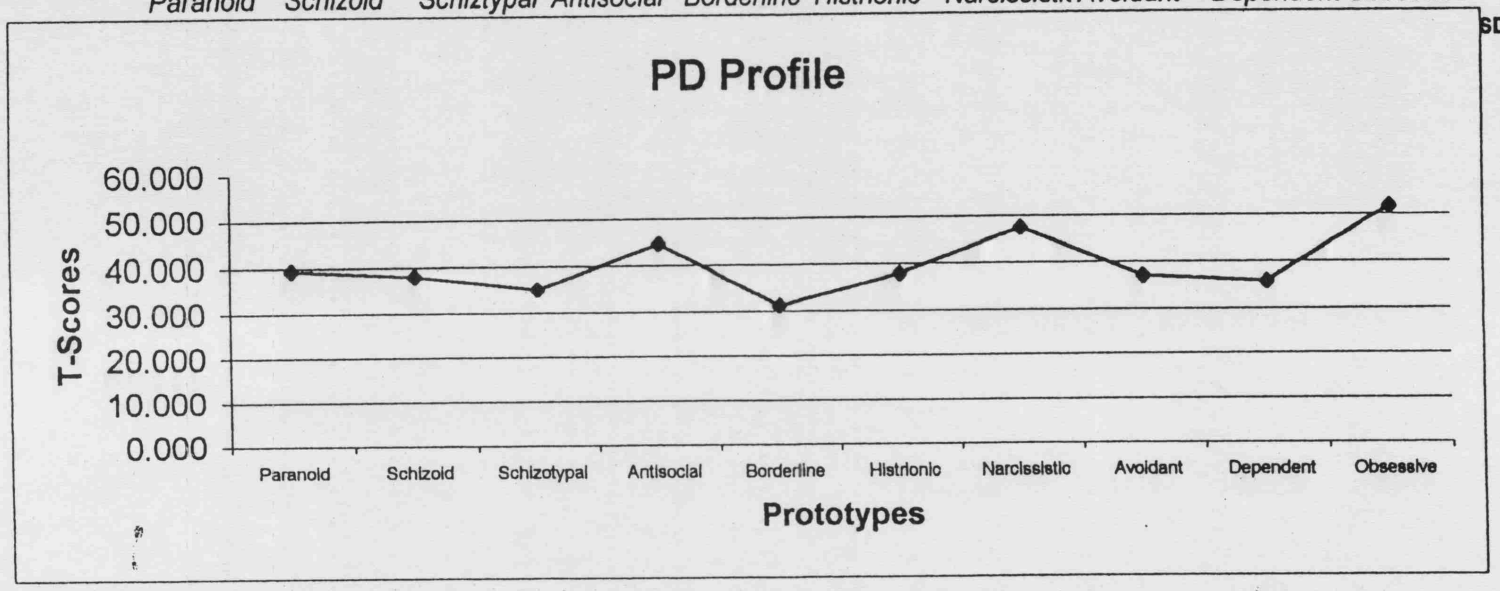
Correlations between sort for this subject and PD norms

Corr. R1	-0.157	-0.191	-0.273	-0.196	-0.169	-0.183	-0.099	-0.060	-0.060	0.143	0.756
Corr. R2	0.062	-0.053	-0.182	-0.061	-0.171	-0.173	0.129	-0.007	-0.081	0.276	0.653
Corr. Av	-0.051	-0.130	-0.242	-0.137	-0.182	-0.190	0.016	-0.036	-0.075	0.224	0.752

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (200) = 0.756
Reliability (11)= 0.936 Hi-fx= 0.752 verage Corr= -0.080 SD(corr)= 0.133 Normality1= 1.239 Normality2= 0.873

T-scores	**39.253**	**38.011**	**35.005**	**44.602**	**31.019**	**37.787**	**47.413**	**36.953**	**35.669**	**51.754**	**Average T= 39.747**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 6.295**



Correlations between sort for this subject and PD norms

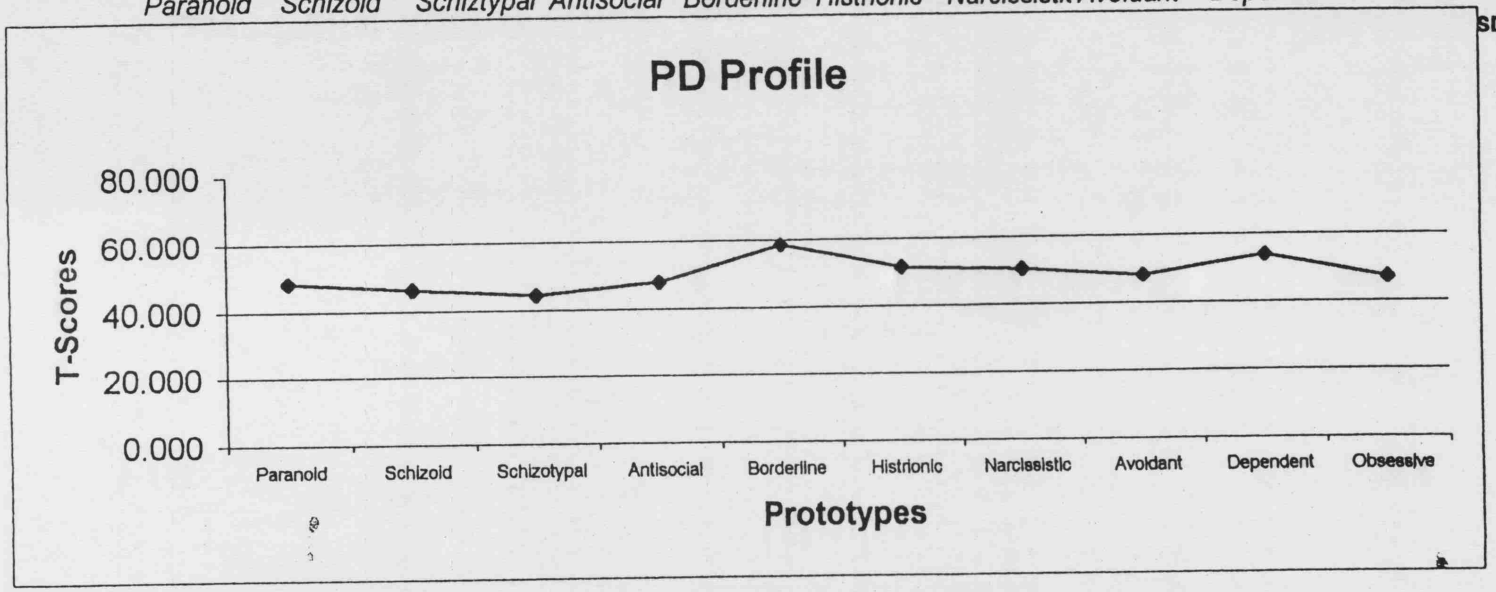
Corr. R1	0.104	0.089	-0.010	-0.101	0.271	0.048	0.038	0.237	0.314	0.133	0.356
Corr. R2	0.156	0.044	-0.062	-0.007	0.330	0.091	0.122	0.218	0.298	0.111	0.288
Corr. Av	**0.135**	**0.069**	**-0.037**	**-0.056**	**0.311**	**0.072**	**0.082**	**0.236**	**0.317**	**0.126**	**0.333**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.864

liability (11)= 0.916 **Hi-fx= 0.333** **verage Corr= 0.125** **SD(corr)= 0.129** **Normality1= 0.584** **Normality2= -0.578**

T-scores	**48.151**	**45.955**	**44.128**	**47.494**	**58.235**	**51.166**	**50.229**	**47.856**	**53.667**	**46.963**	**Average T= 49.384**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 4.127**



Profiles210c

Correlations between sort for this subject and PD norms

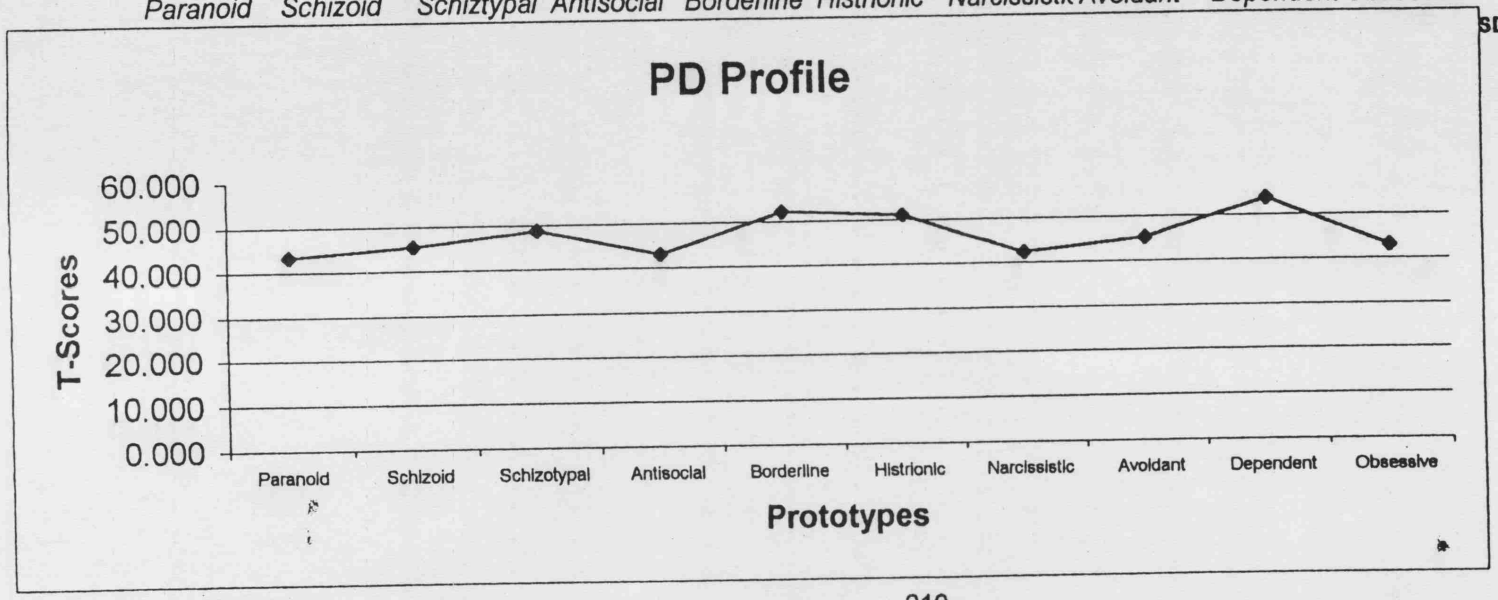
Corr. R1	0.100	0.083	0.100	-0.151	0.203	0.089	-0.045	0.189	0.296	0.047	0.202
Corr. R2	-0.038	0.019	0.024	-0.187	0.169	0.038	-0.153	0.130	0.295	0.035	0.350
Corr. Av	**0.033**	**0.055**	**0.067**	**-0.182**	**0.200**	**0.068**	**-0.107**	**0.171**	**0.318**	**0.044**	**0.298**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.724

liability (11)= 0.911 **Hi-fx= 0.298** **verage Corr= 0.067** **SD(corr)= 0.144** **Normality1= 0.756** **Normality2= -0.230**

T-scores	**43.292**	**45.417**	**48.739**	**42.992**	**52.117**	**50.989**	**42.212**	**45.280**	**53.713**	**42.923**	**Average T= 46.767**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 4.275**



Profiles253

Correlations between sort for this subject and PD norms

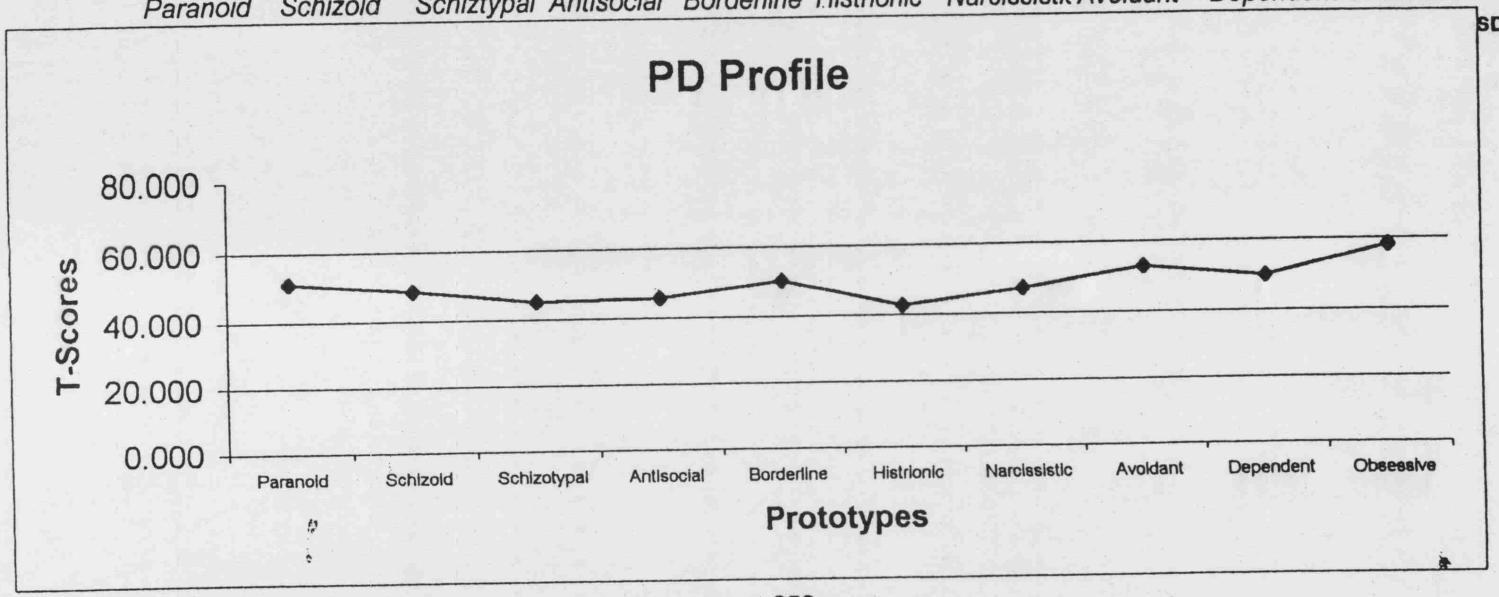
Corr. R1	0.160	0.017	-0.114	-0.096	0.145	-0.087	0.006	0.258	0.183	0.298	0.455
Corr. R2	0.195	0.228	0.085	-0.104	0.157	-0.089	0.006	0.401	0.239	0.353	0.267
Corr. Av	**0.192**	**0.133**	**-0.015**	**-0.108**	**0.164**	**-0.096**	**0.007**	**0.358**	**0.229**	**0.353**	**0.392**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.698

liability (11)= 0.802 Hi-fx= 0.392 verage Corr= 0.122 SD(corr)= 0.170 Normality1= 0.659 Normality2= -0.500

T-scores	**50.936**	**48.510**	**45.097**	**45.628**	**50.117**	**42.624**	**47.029**	**52.752**	**49.631**	**58.137**	**Average T= 49.046**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 4.401**



Profiles337

Correlations between sort for this subject and PD norms

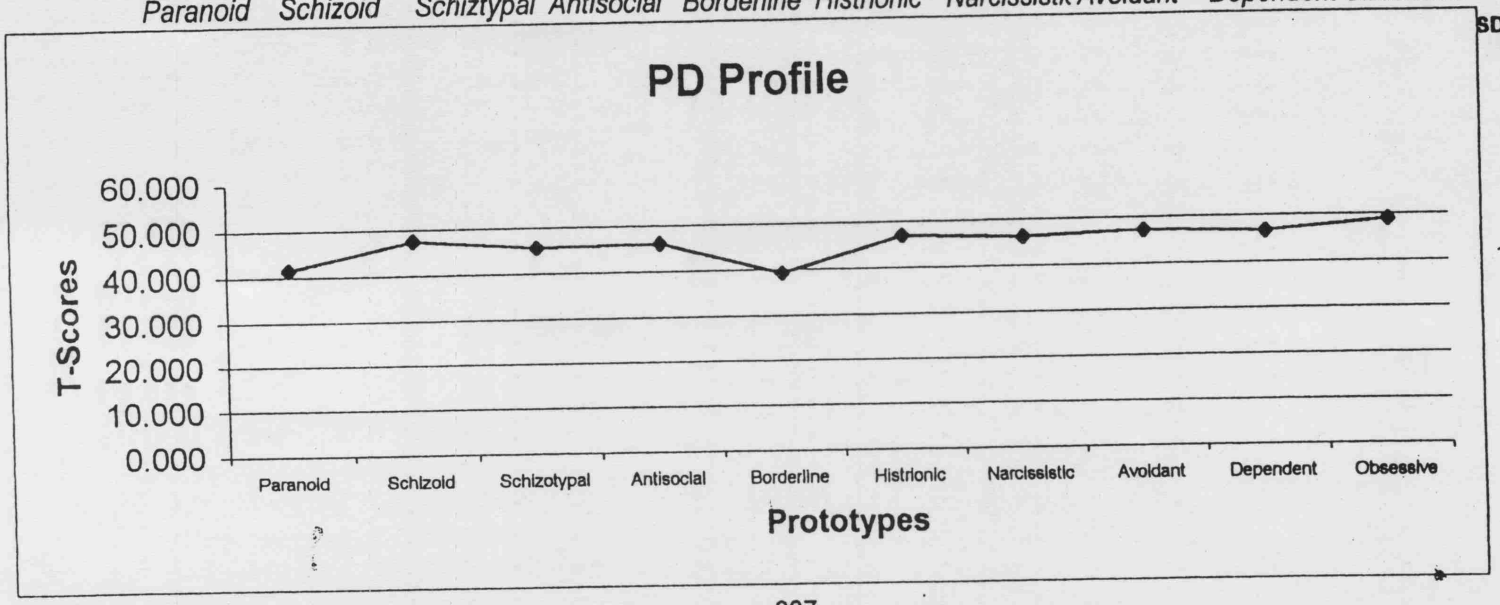
Corr. R1	-0.012	0.086	-0.012	-0.097	-0.028	0.008	-0.010	0.199	0.168	0.147	0.356
Corr. R2	0.003	0.124	0.003	-0.099	-0.044	-0.036	-0.017	0.232	0.154	0.182	0.374
Corr. Av	**-0.005**	**0.105**	**-0.004**	**-0.099**	**-0.036**	**-0.014**	**-0.014**	**0.217**	**0.162**	**0.165**	**0.367**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.978

liability (11)= 0.987 Hi-fx= 0.367 verage Corr= 0.048 SD(corr)= 0.106 Normality 1= 0.863 Normality 2= 0.188

T-scores	**41.455**	**47.416**	**45.586**	**45.970**	**39.038**	**46.777**	**46.155**	**47.103**	**46.541**	**48.888**	**Average T= 45.493**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 2.967**



337

716

Profiles361

Correlations between sort for this subject and PD norms

Corr. R1	0.036	-0.089	-0.151	0.412	-0.128	0.066	0.326	-0.215	-0.300	-0.057	0.298
Corr. R2	-0.057	-0.136	-0.185	0.262	-0.146	0.186	0.330	-0.218	-0.215	-0.042	0.330
Corr. Av	**-0.011**	**-0.121**	**-0.180**	**0.361**	**-0.147**	**0.135**	**0.351**	**-0.232**	**-0.275**	**-0.053**	**0.336**

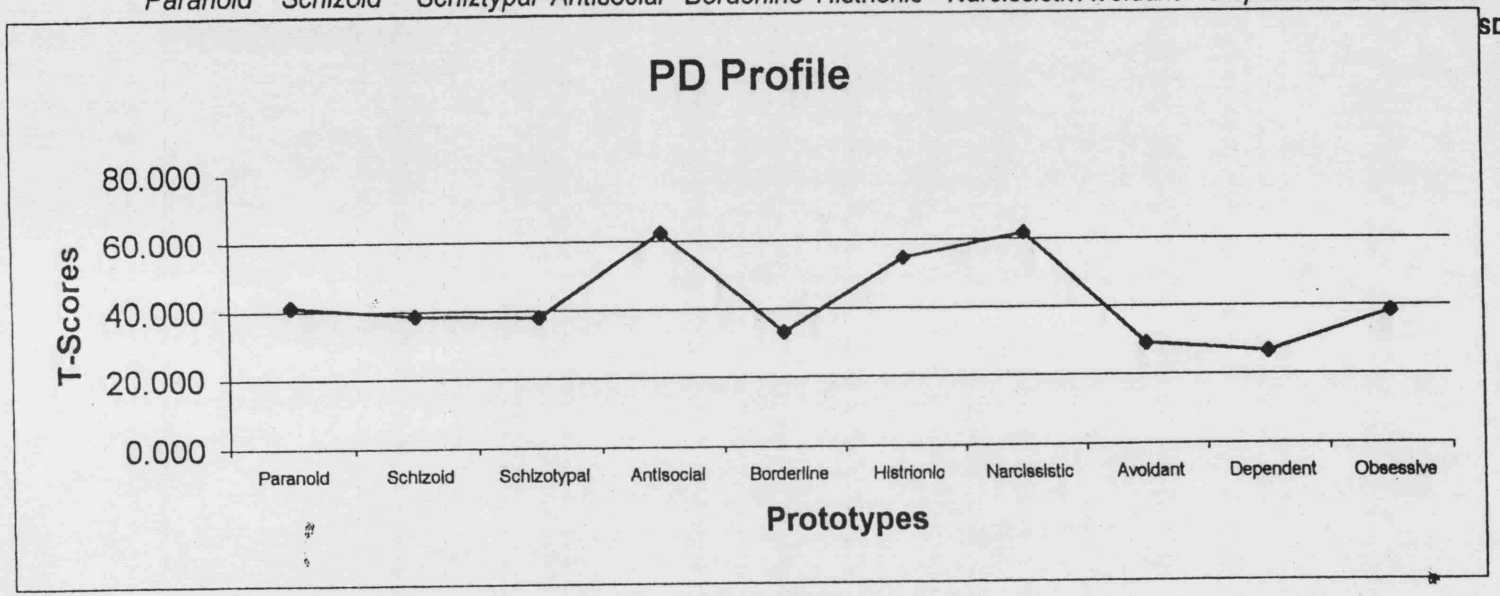
ability (200) = 0.743

Agreement between raters in their correlations with PD Profile and T-scores

liability (11)= 0.947 **Hi-fx= 0.336** **verage Corr= -0.017** **SD(corr)= 0.228** **Normality1= 1.050** **Normality2= 0.103**

T-scores	**41.132**	**38.370**	**37.772**	**62.378**	**32.942**	**54.406**	**61.615**	**29.073**	**26.496**	**38.136**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**42.232**

SD(T-score)=
12.865



Profiles390

Correlations between sort for this subject and PD norms

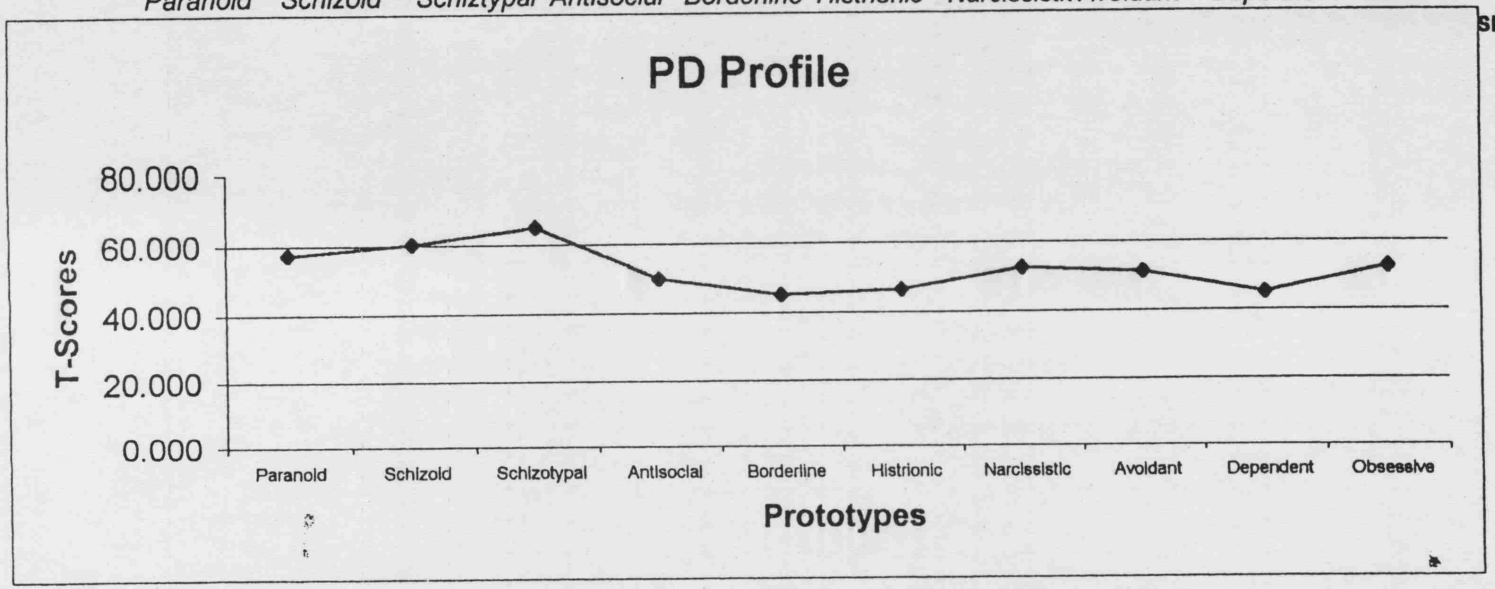
Corr. R1	0.344	0.424	0.435	0.037	0.030	-0.020	0.167	0.281	0.088	0.255	-0.068
Corr. R2	0.259	0.381	0.380	-0.032	0.098	-0.027	0.082	0.311	0.152	0.190	0.033
Corr. Av	**0.319**	**0.425**	**0.430**	**0.003**	**0.067**	**-0.024**	**0.132**	**0.312**	**0.127**	**0.235**	**-0.019**

ability (200) = 0.794

Agreement between raters in their correlations with PD Profile and T-scores

liability (11)= 0.929 **Hi-fx= -0.019** **verage Corr= 0.203** **SD(corr)= 0.166** **Normality1= -1.088** **Normality2= -0.999**

T-scores	**56.999**	**60.206**	**64.894**	**49.602**	**44.778**	**46.250**	**52.319**	**50.931**	**44.953**	**52.312**	**Average T= 52.324**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 6.663**



718

Profiles399c

Correlations between sort for this subject and PD norms

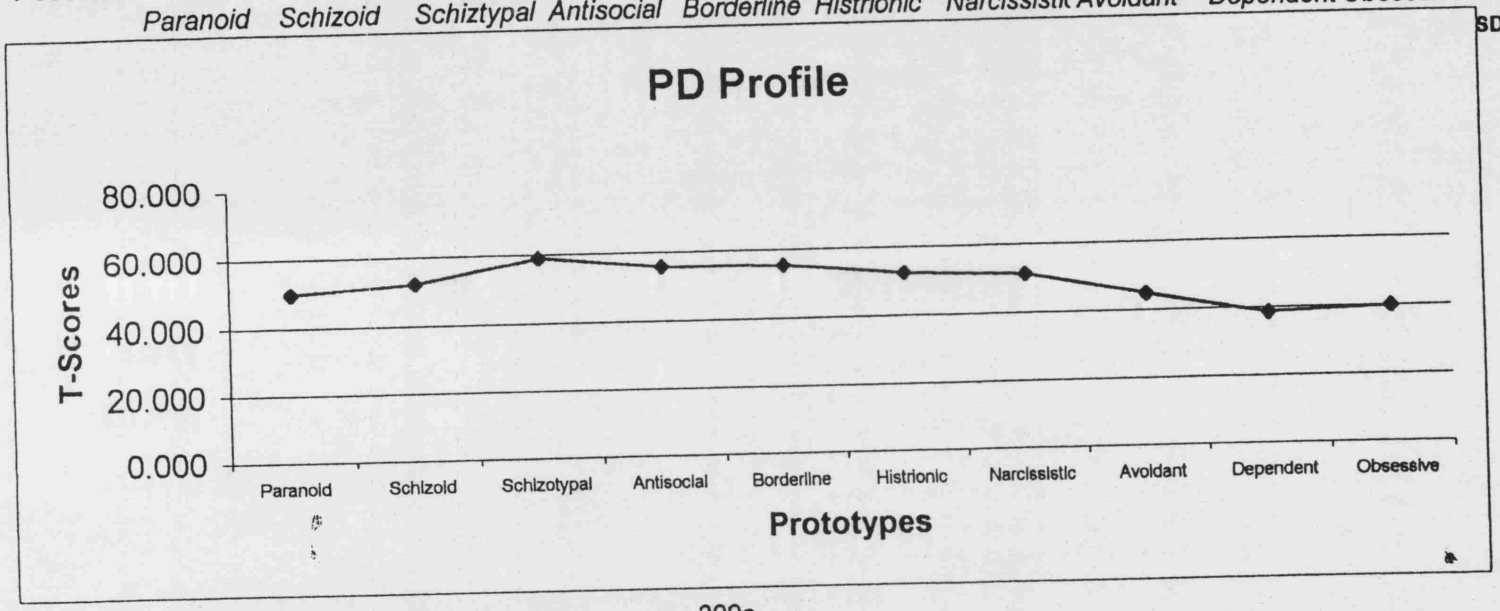
Corr. R1	0.190	0.252	0.295	0.107	0.221	0.009	0.047	0.194	-0.022	-0.022	0.078
Corr. R2	0.110	0.154	0.250	0.204	0.257	0.161	0.140	0.089	-0.005	-0.020	0.020
Corr. Av	**0.161**	**0.218**	**0.293**	**0.167**	**0.257**	**0.091**	**0.100**	**0.152**	**-0.015**	**-0.022**	**0.053**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.733

liability (11)= 0.670 **HI-fx= 0.053** **verage Corr= 0.140** **SD(corr)= 0.105** **Normality1= -0.585** **Normality2= -0.988**

T-scores	**49.430**	**51.929**	**58.788**	**55.473**	**55.234**	**52.142**	**50.994**	**44.501**	**38.456**	**39.640**	**Average T= 49.659**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 6.781**



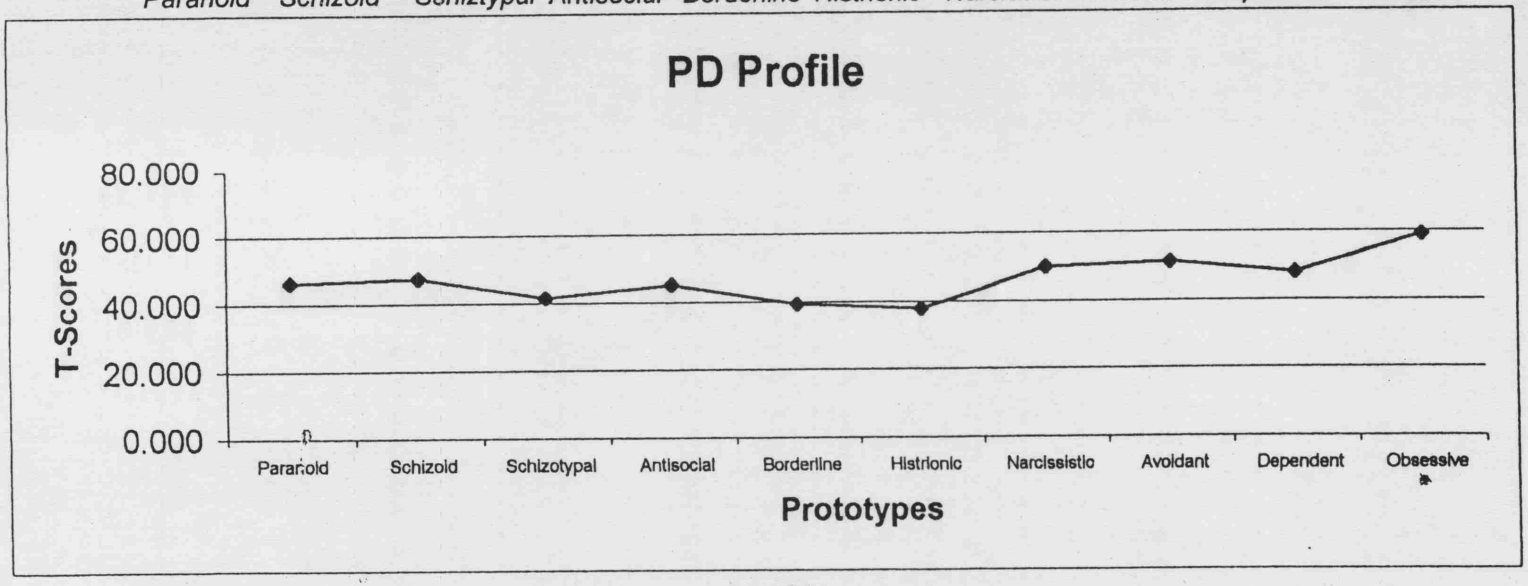
399c

Correlations between sort for this subject and PD norms

Corr. R1	0.041	0.124	-0.072	-0.189	-0.010	-0.176	-0.025	0.350	0.238	0.321	0.584
Corr. R2	0.044	0.025	-0.136	-0.156	0.017	-0.135	0.045	0.315	0.204	0.297	0.557
Corr. R3	0.144	0.080	-0.108	-0.036	-0.052	-0.187	0.159	0.253	0.124	0.369	0.516
Corr. Av	**0.098**	**0.108**	**-0.096**	**-0.120**	**-0.033**	**-0.193**	**0.071**	**0.320**	**0.192**	**0.366**	**0.583**

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (2(	R1vR2= 0.796		R1vR3= 0.777		R2vR3= 0.717		Mean= 0.763				
Reliability (1'	R1vR2= 0.980		R1vR3= 0.910		R2vR3= 0.935		Mean= 0.941		Hi-fx=	0.583	
Average Cori 0.072		SD(corr)=	0.186	Normality1=	0.871	Normality2=	0.203	Average T=	46.531	SD (Tscore)=	6.182
T-scores	**46.411**	**47.538**	**41.522**	**45.225**	**39.228**	**37.676**	**49.748**	**51.246**	**47.944**	**58.769**	
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	*Hi-Fx*



Correlations between sort for this subject and PD norms

Corr. R1	-0.028	-0.165	-0.261	-0.077	-0.087	-0.172	0.080	-0.026	-0.058	0.260	0.590
Corr. R2	-0.030	-0.104	-0.224	-0.143	-0.136	-0.206	-0.007	0.075	0.037	0.358	0.612
Corr. Av	**-0.031**	**-0.142**	**-0.256**	**-0.116**	**-0.118**	**-0.199**	**0.038**	**0.026**	**-0.011**	**0.326**	**0.635**

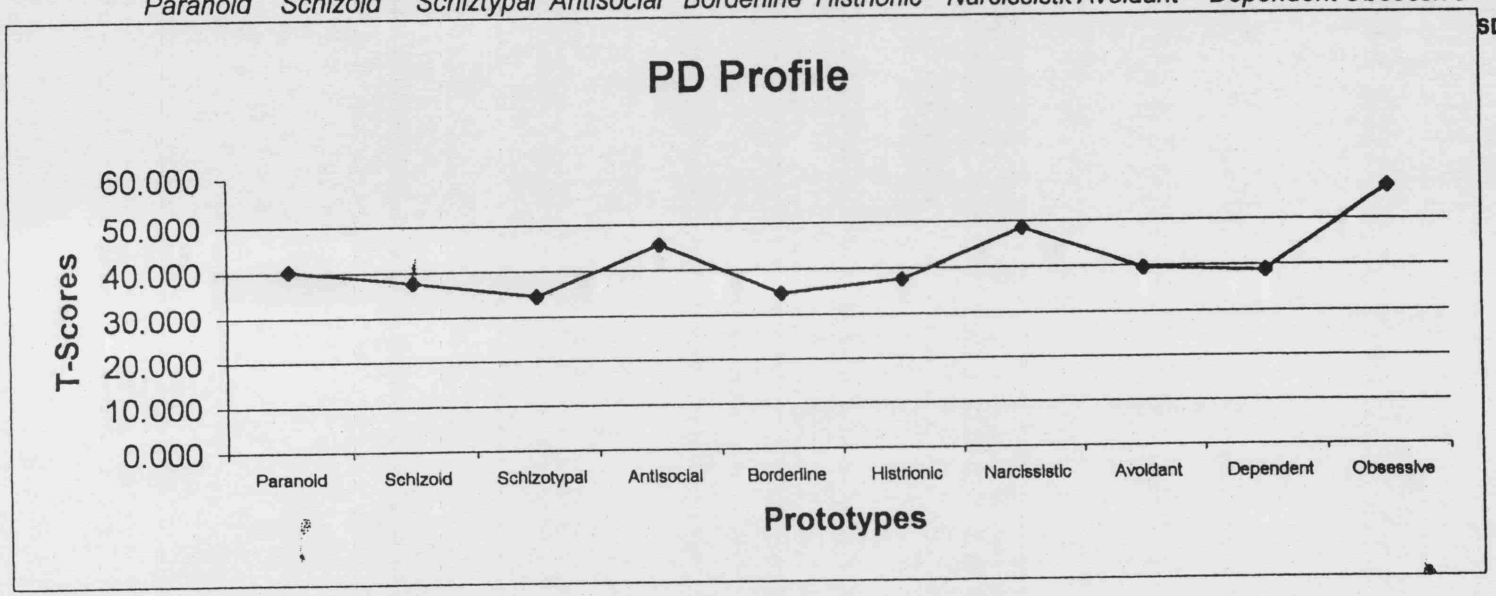
ability (200) = 0.795

Agreement between raters in their correlations with PD Profile and T-scores

liability (11)= 0.964 **Hi-fx= 0.635** **verage Corr= -0.048** **SD(corr)= 0.163** **Normality1= 1.073** **Normality2= 0.790**

T-scores	**40.204**	**37.509**	**34.407**	**45.343**	**34.543**	**37.327**	**48.352**	**39.437**	**38.613**	**56.805**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**41.254**

SD(T-score)= 7.005



Profiles454

Correlations between sort for this subject and PD norms

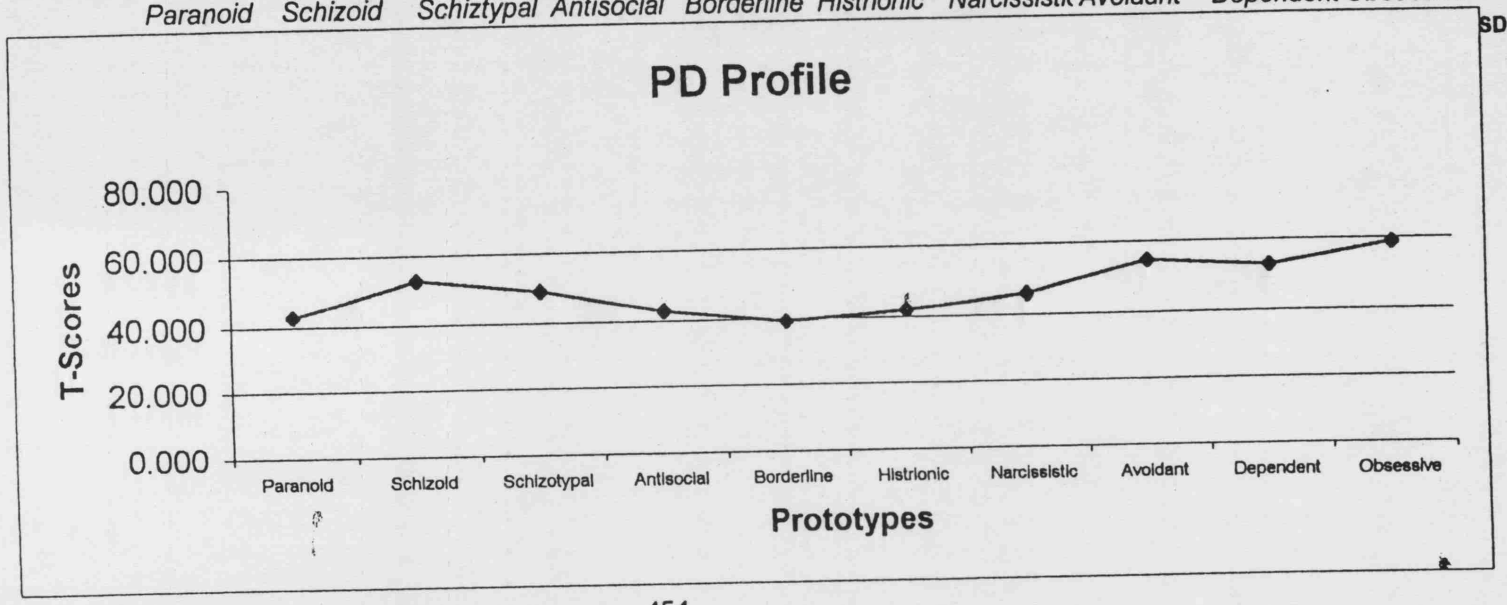
Corr. R1	0.018	0.240	0.144	-0.154	-0.001	0.007	0.012	0.360	0.342	0.254	0.426
Corr. R2	0.024	0.192	-0.014	-0.192	-0.062	-0.213	-0.060	0.376	0.201	0.421	0.597
Corr. Av	**0.022**	**0.233**	**0.070**	**-0.187**	**-0.034**	**-0.111**	**-0.026**	**0.397**	**0.293**	**0.364**	**0.552**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.720

liability (11)= 0.909 **Hi-fx= 0.552** **verage Corr= 0.102** **SD(corr)= 0.205** **Normality1= 0.801** **Normality2= -0.146**

T-scores	**42.762**	**52.511**	**48.910**	**42.833**	**39.171**	**41.832**	**45.636**	**54.328**	**52.565**	**58.663**	**Average T= 47.921**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 6.424**



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722

Profiles494

Correlations between sort for this subject and PD norms

Corr. R1	-0.174	-0.121	-0.158	-0.091	-0.048	-0.105	-0.184	-0.050	-0.057	0.008	0.631
Corr. R2	-0.108	-0.072	-0.126	-0.055	-0.018	-0.046	-0.121	0.016	0.016	0.023	0.586
Corr. Av	**-0.148**	**-0.101**	**-0.149**	**-0.077**	**-0.035**	**-0.080**	**-0.160**	**-0.018**	**-0.021**	**0.016**	**0.639**

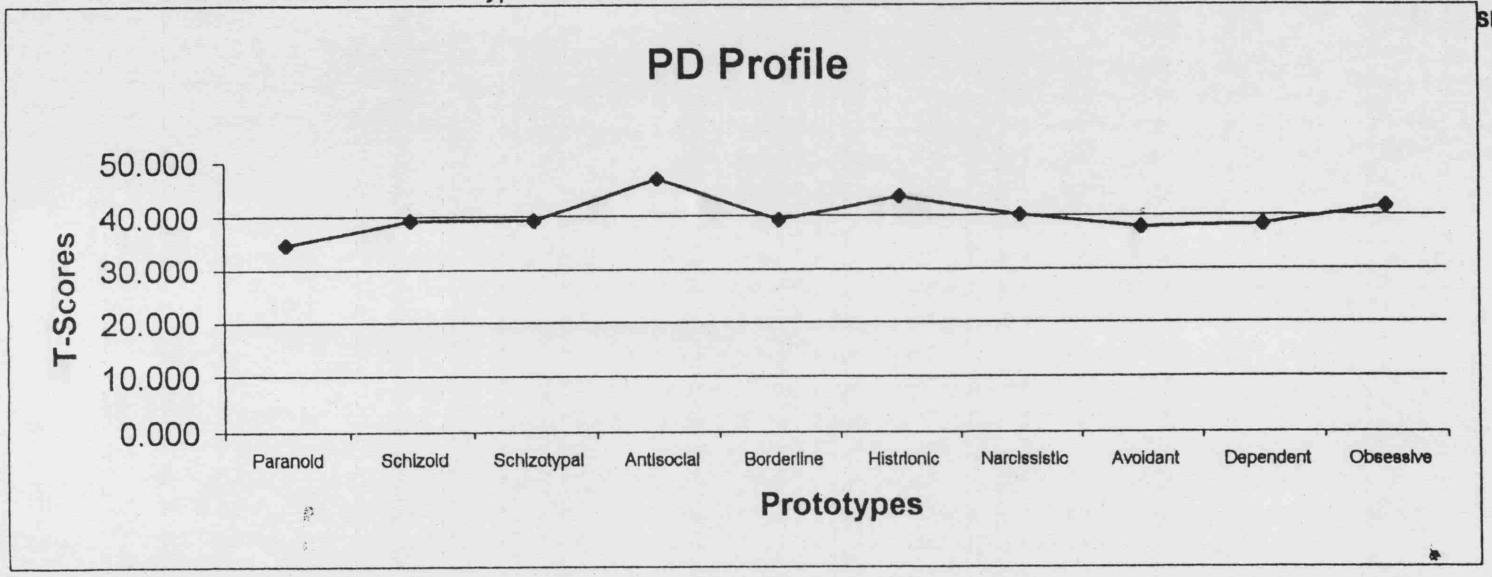
ability (200) = 0.809

Agreement between raters in their correlations with PD Profile and T-scores

liability (11)= 0.996 **HI-fx= 0.639** **verage Corr= -0.077** **SD(corr)= 0.062** **Normality1= 1.113** **Normality2= 0.999**

T-scores	**34.563**	**39.145**	**39.145**	**46.758**	**39.137**	**43.434**	**39.942**	**37.677**	**38.148**	**41.549**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**39.950**

SD(T-score)= 3.341



Profiles496

Correlations between sort for this subject and PD norms

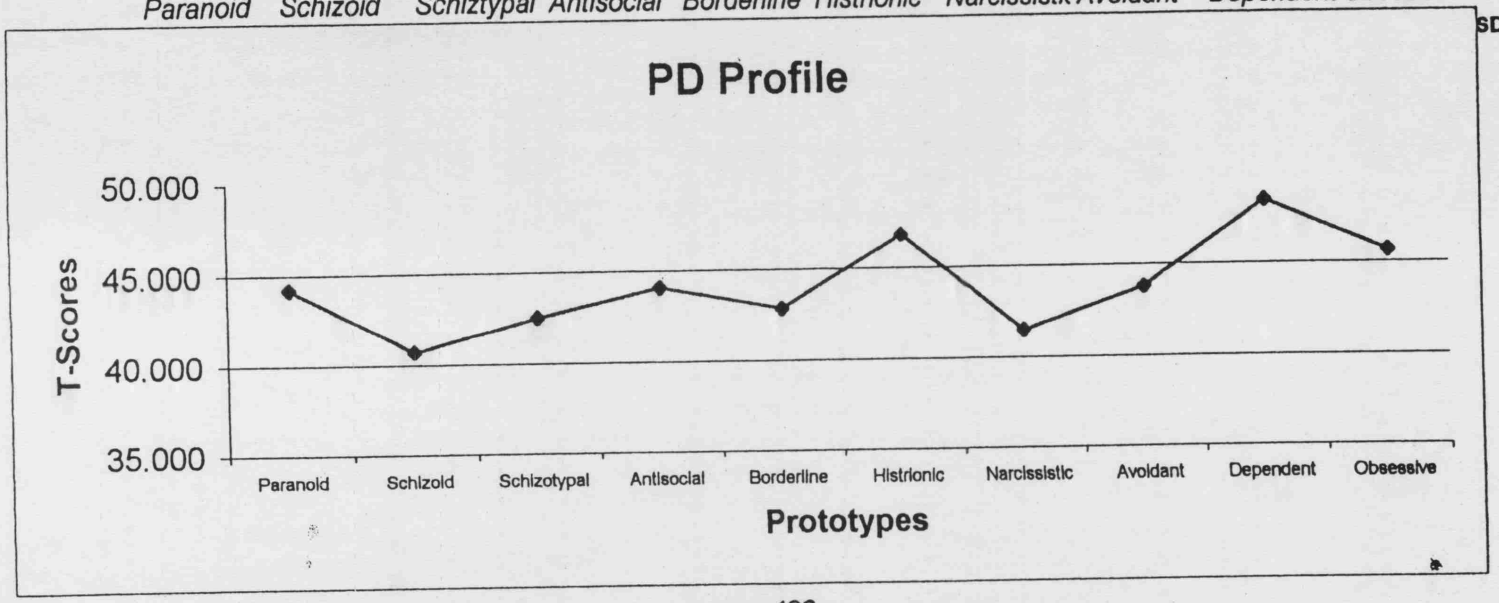
Corr. R1	0.021	-0.056	-0.103	-0.130	0.028	-0.046	-0.144	0.128	0.172	0.090	0.443
Corr. R2	0.077	-0.059	-0.035	-0.154	0.033	0.020	-0.087	0.122	0.206	0.096	0.404
Corr. Av	**0.053**	**-0.062**	**-0.074**	**-0.152**	**0.033**	**-0.014**	**-0.124**	**0.134**	**0.203**	**0.099**	**0.454**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.742

liability (11)= 0.978 **Hi-fx= 0.454** **verage Corr= 0.010** **SD(corr)= 0.115** **Normality1= 0.979** **Normality2= 0.686**

T-scores	**44.218**	**40.721**	**42.511**	**44.054**	**42.855**	**46.804**	**41.479**	**43.772**	**48.419**	**45.638**	**Average T= 44.047**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 2.375**



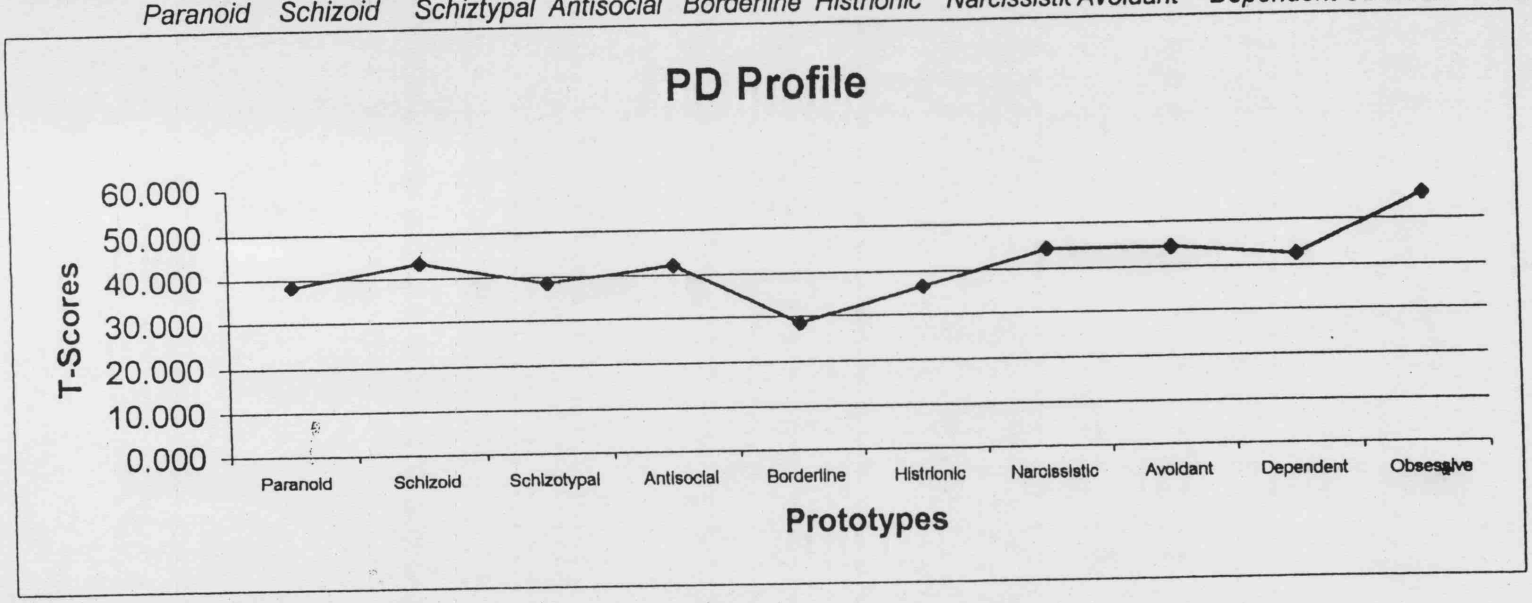
Correlations between sort for this subject and PD norms

Corr. R1	-0.110	0.052	-0.104	-0.239	-0.260	-0.189	-0.125	0.163	0.124	0.267	0.708
Corr. R2	-0.059	0.040	-0.135	-0.237	-0.240	-0.269	-0.147	0.254	0.121	0.360	0.727
Corr. R3	-0.028	-0.045	-0.208	-0.148	-0.169	-0.221	0.022	0.123	0.018	0.301	0.725
Corr. Av	**-0.073**	**0.004**	**-0.166**	**-0.205**	**-0.228**	**-0.217**	**-0.054**	**0.152**	**0.076**	**0.301**	**0.760**

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (2(	R1vR2= 0.800		R1vR3= 0.778		R2vR3= 0.783		Mean= 0.787			
Reliability (1'	R1vR2= 0.988		R1vR3= 0.950		R2vR3= 0.954		Mean= 0.964		Hi-fx=	0.760
Average Cori -0.041		SD(corr)= 0.176		Normality1= 1.053		Normality2= 0.831		Average T= 41.407		SD (Tscore)= 6.971

T-scores	**38.164**	**43.346**	**38.421**	**42.165**	**28.468**	**36.408**	**44.432**	**44.484**	**42.594**	**55.588**	
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	*Hi-Fx*

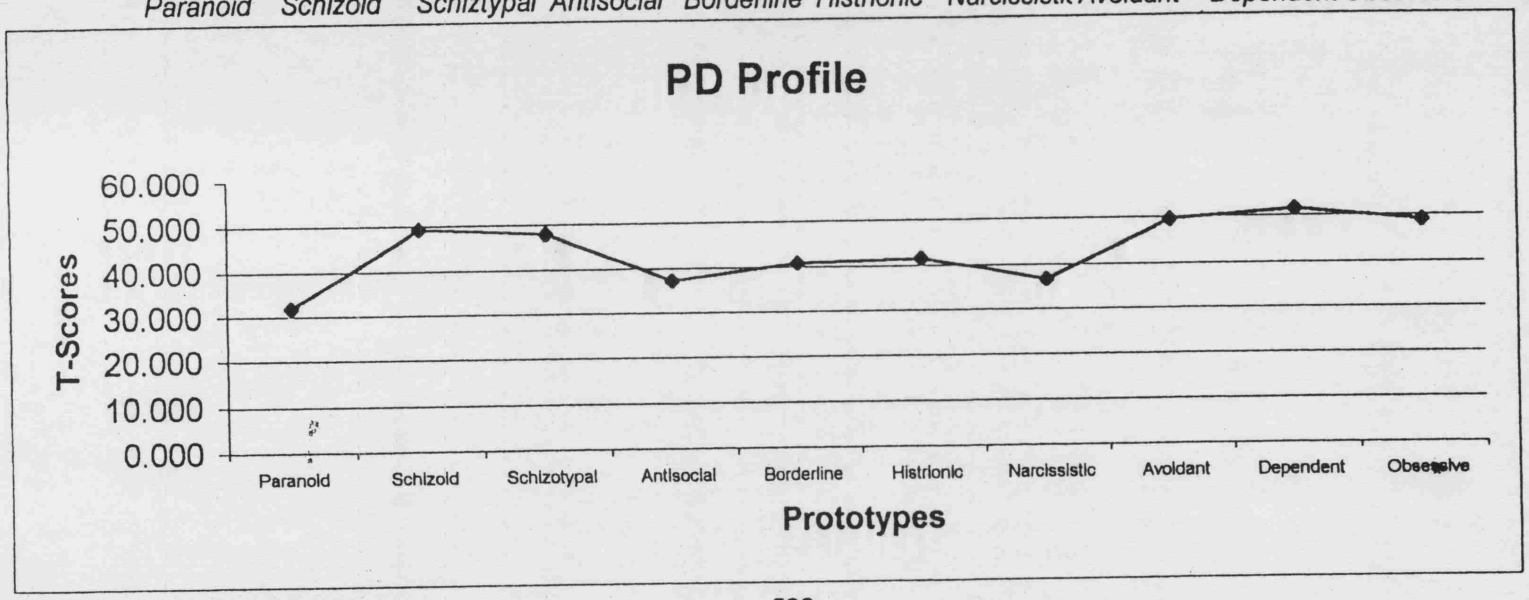


Correlations between sort for this subject and PD norms

Corr. R1	-0.129	0.233	0.163	-0.269	0.016	-0.060	-0.193	0.266	0.207	0.146	0.232
Corr. R2	-0.160	0.125	0.071	-0.223	0.040	-0.054	-0.197	0.230	0.199	0.207	0.155
Corr. R3	-0.250	0.041	-0.075	-0.365	-0.023	-0.156	-0.242	0.243	0.287	0.160	0.423
Corr. Av	**-0.206**	**0.149**	**0.048**	**-0.345**	**-0.003**	**-0.117**	**-0.237**	**0.277**	**0.269**	**0.166**	**0.356**

Agreement between raters in their correlations with PD Profile and T-scores

Reliability (2(	R1vR2= 0.651		R1vR3= 0.688		R2vR3= 0.604		Mean= 0.648				
Reliability (1'	R1vR2= 0.961		R1vR3= 0.887		R2vR3= 0.912		Mean= 0.920		Hi-fx=	0.356	
Average Cori 0.000		SD(corr)=	0.219	Normality1=	1.000	Normality2=	0.382	Average T=	43.502	SD (Tscore)=	6.790
T-scores	**31.779**	**49.152**	**47.906**	**37.180**	**40.861**	**41.518**	**36.706**	**49.518**	**51.472**	**48.927**	
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	*Hi-Fx*



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Profiles503

Correlations between sort for this subject and PD norms

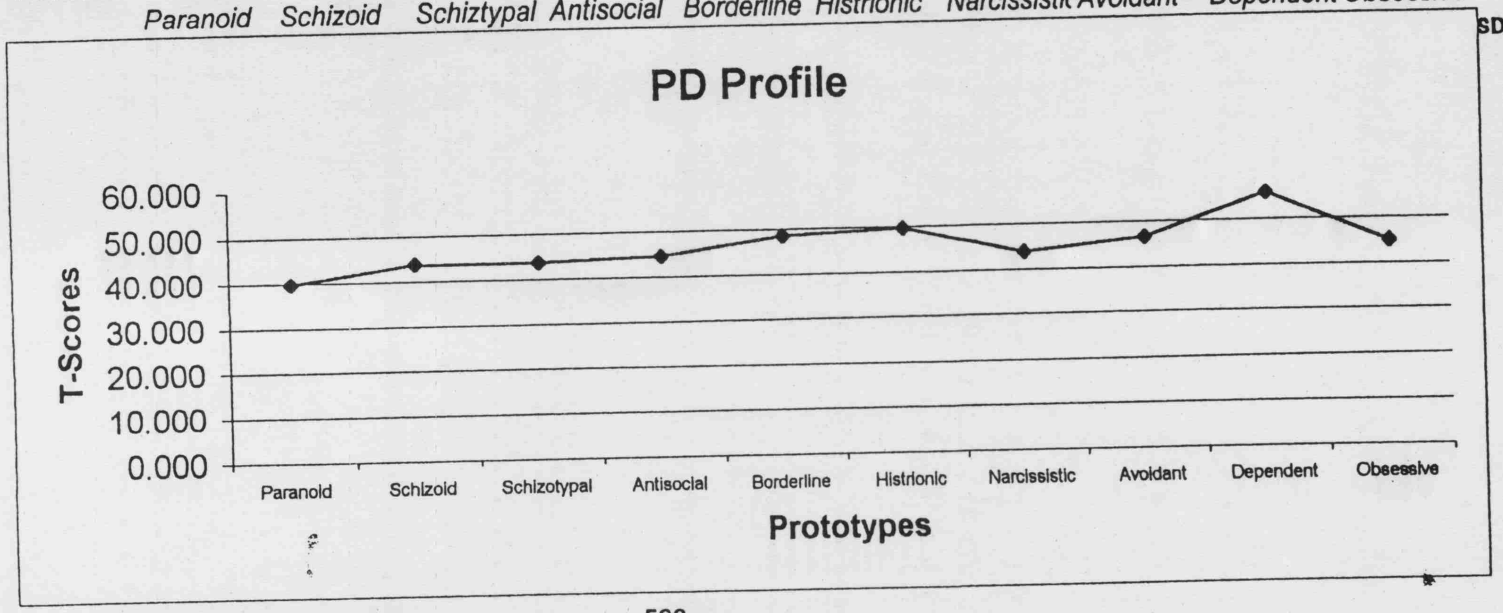
Corr. R1	-0.091	-0.030	-0.100	-0.175	0.084	-0.034	-0.127	0.182	0.314	0.068	0.543
Corr. R2	0.015	0.061	0.014	-0.083	0.160	0.110	-0.001	0.189	0.353	0.091	0.327
Corr. Av	**-0.041**	**0.017**	**-0.047**	**-0.140**	**0.132**	**0.041**	**-0.070**	**0.201**	**0.361**	**0.086**	**0.471**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.704

liability (11)= 0.941 **Hi-fx= 0.471** **verage Corr= 0.054** **SD(corr)= 0.148** **Normality1= 0.879** **Normality2= 0.165**

T-scores	**39.721**	**43.878**	**43.702**	**44.504**	**48.334**	**49.608**	**43.789**	**46.481**	**55.694**	**44.962**	**Average T= 46.067**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 4.347**



503

727

Correlations between sort for this subject and PD norms

Corr. R1	0.198	-0.107	-0.165	0.164	-0.171	-0.086	0.322	-0.133	-0.220	0.174	0.488
Corr. R2	0.153	0.125	0.019	0.058	-0.219	-0.229	0.159	-0.041	-0.218	0.344	0.447
Corr. Av	0.190	0.009	-0.079	0.120	-0.211	-0.171	0.261	-0.094	-0.238	0.281	0.507

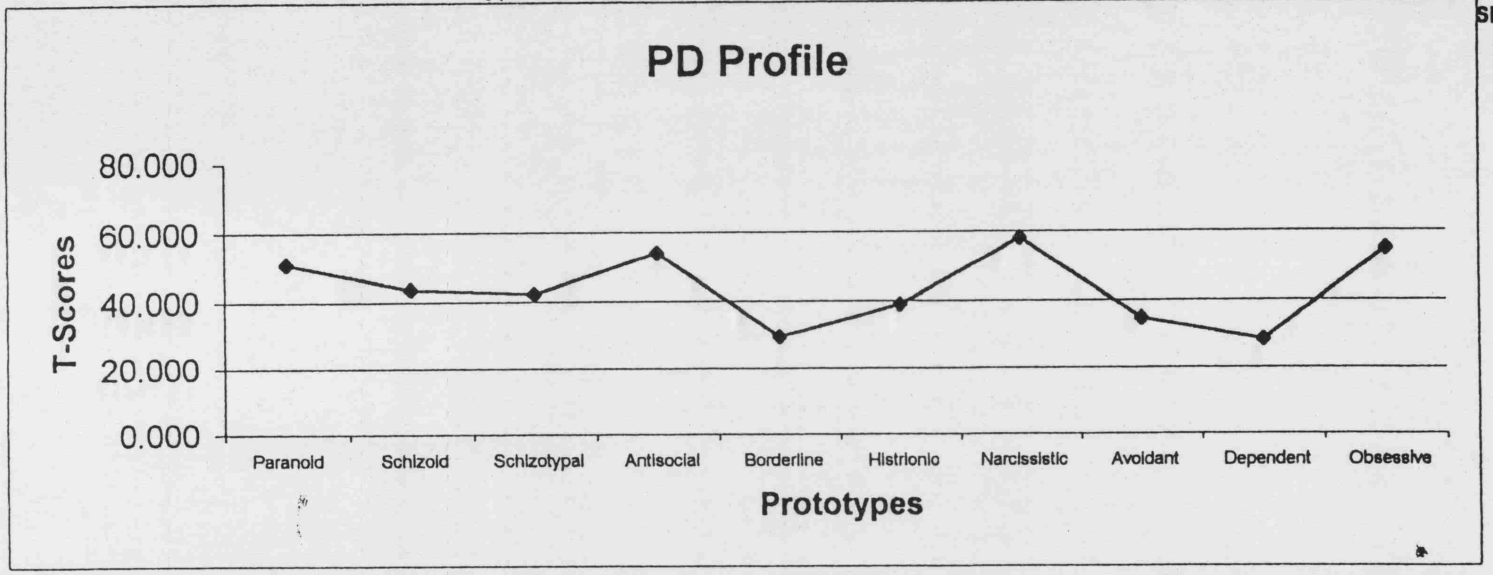
ability (200) = 0.700

Agreement between raters in their correlations with PD Profile and T-scores

liability (11)= 0.824 **Hi-fx= 0.507** **verage Corr= 0.007** **SD(corr)= 0.195** **Normality1= 0.973** **Normality2= 0.341**

T-scores	**50.812**	**43.579**	**42.262**	**53.796**	**29.369**	**38.798**	**57.792**	**34.602**	**28.227**	**54.565**	**Average T=**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**43.380**

SD(T-score)=
10.655



Profiles514

Correlations between sort for this subject and PD norms

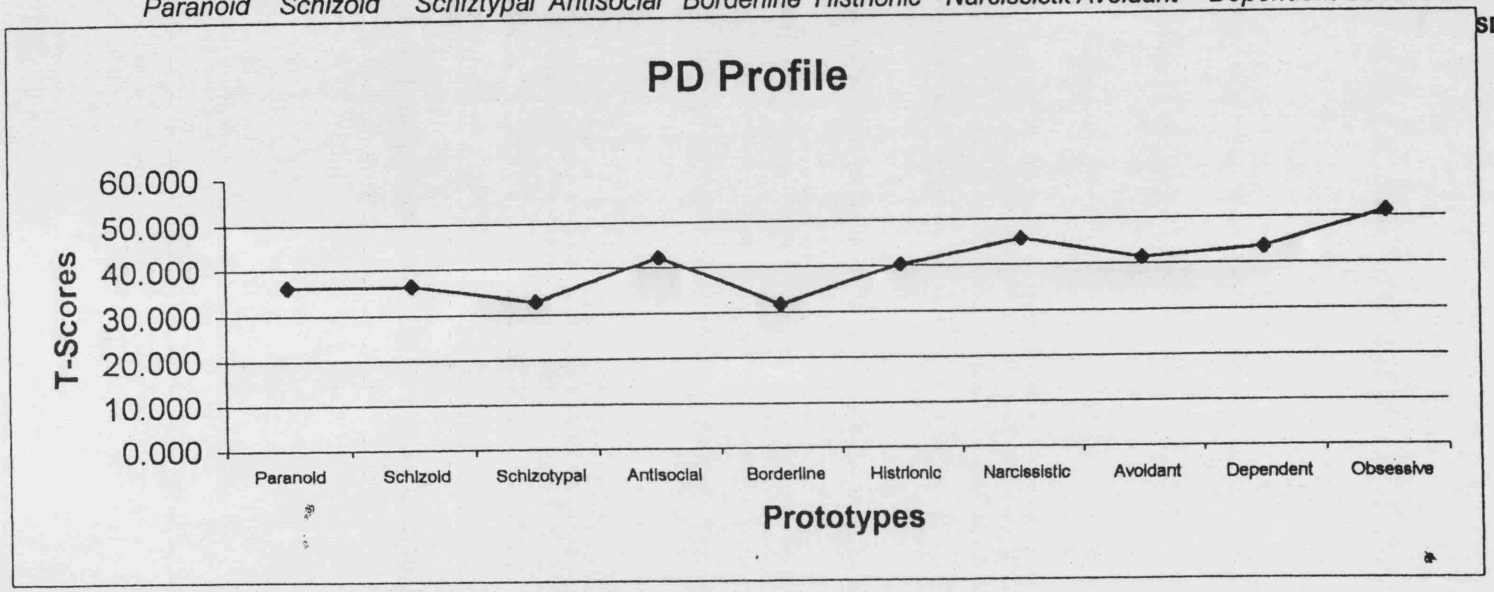
Corr. R1	-0.140	-0.165	-0.267	-0.235	-0.175	-0.142	-0.065	0.073	0.075	0.126	0.792
Corr. R2	-0.080	-0.170	-0.297	-0.162	-0.151	-0.133	0.012	0.061	0.106	0.275	0.788
Corr. Av	**-0.115**	**-0.175**	**-0.295**	**-0.207**	**-0.170**	**-0.144**	**-0.028**	**0.070**	**0.094**	**0.210**	**0.827**

Agreement between raters in their correlations with PD Profile and T-scores

ability (200) = 0.827

liability (11)= 0.985 **Hi-fx= 0.827** **verage Corr= -0.076** **SD(corr)= 0.158** **Normality1= 1.087** **Normality2= 0.934**

T-scores	**36.151**	**36.194**	**32.673**	**42.093**	**31.648**	**40.145**	**45.571**	**41.206**	**43.455**	**51.085**	**Average T= 40.022**
	Paranoid	*Schizoid*	*Schiztypal*	*Antisocial*	*Borderline*	*Histrionic*	*Narcissistic*	*Avoidant*	*Dependent*	*Obsessive*	**SD(T-score)= 6.004**



Westenv2rater(1)

Correlations between sort for this subject and Q-score norms

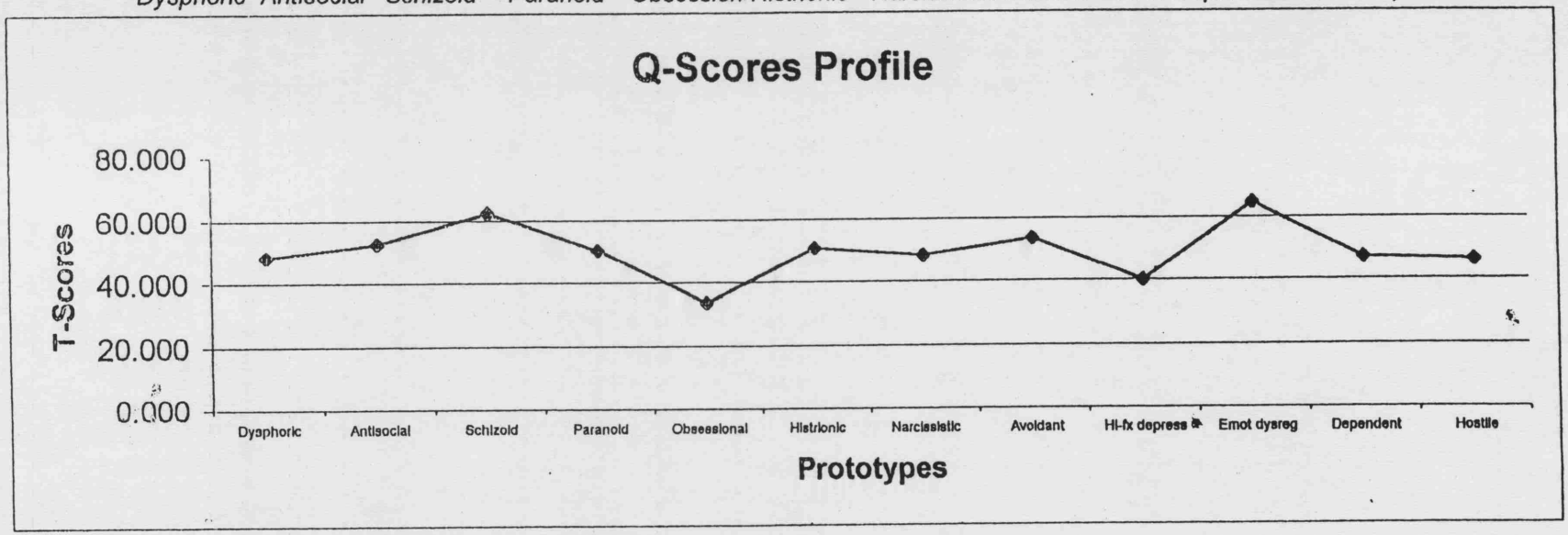
Corr. R1	0.251	0.156	0.363	0.102	-0.231	-0.002	0.002	0.307	-0.107	0.404	0.014	0.125	-0.199
Corr. R2	0.193	0.140	0.376	0.186	-0.221	0.155	0.019	0.215	-0.106	0.426	0.032	0.154	-0.208
Corr. Av	**0.236**	**0.157**	**0.393**	**0.153**	**-0.240**	**0.081**	**0.012**	**0.277**	**-0.113**	**0.442**	**0.024**	**0.148**	**-0.216**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13) 0.946 **Hi-fx= -0.216** **Average Corr= 0.113** **SD(corr)= 0.197** **Normality1= -1.349** **Normality2= -0.765**

Average T scores (Q1-Q7)= 49.285 **SD(T-scores) 8.498** **Average T scores (Q1a-Q1 50.151** **SD(T-scores) 9.369**

T-scores	**48.073**	**52.423**	**62.147**	**50.201**	**33.383**	**50.566**	**48.207**	**53.552**	**39.732**	**64.437**	**46.986**	**46.047**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



Westenv2rater(1)

Correlations between sort for this subject and Q-score norms

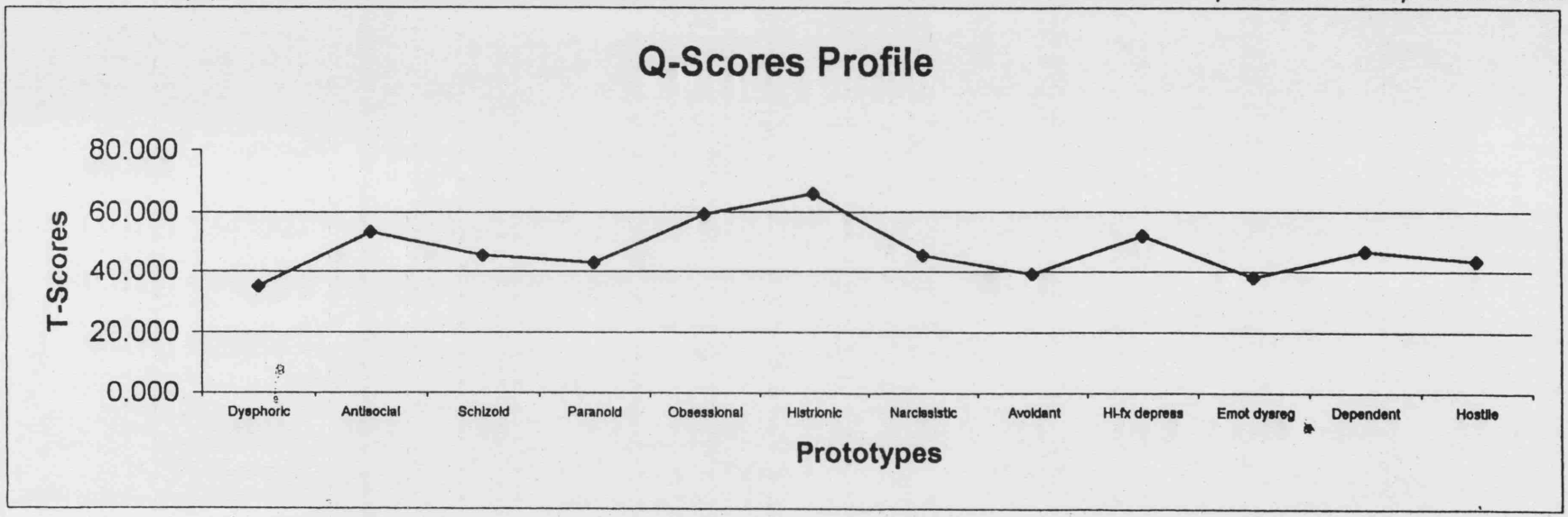
Corr. R1	-0.159	0.213	0.023	-0.020	0.343	0.289	-0.029	-0.147	0.144	-0.134	0.015	0.106
Corr. R2	-0.042	0.129	-0.035	0.042	0.342	0.342	-0.023	-0.117	0.242	-0.036	0.019	0.096
Corr. Av	**-0.106**	**0.180**	**-0.007**	**0.012**	**0.360**	**0.332**	**-0.027**	**-0.139**	**0.202**	**-0.089**	**0.018**	**0.106**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13)= 0.931 Hi-fx= 0.365 verage Corr= 0.106 SD(corr)= 0.185 Normality1= 0.680 Normality2= -0.955

Average T scores (Q1-Q7)= 49.515 SD(T-scores) 10.527 Average T scores (Q1a-Q1 43.788 SD(T-scores) 5.721

T-scores	**34.873**	**53.341**	**45.356**	**42.879**	**59.148**	**65.751**	**45.257**	**39.099**	**51.908**	**37.887**	**46.625**	**43.420**
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*



Westenv2rater(1)

Correlations between sort for this subject and Q-score norms

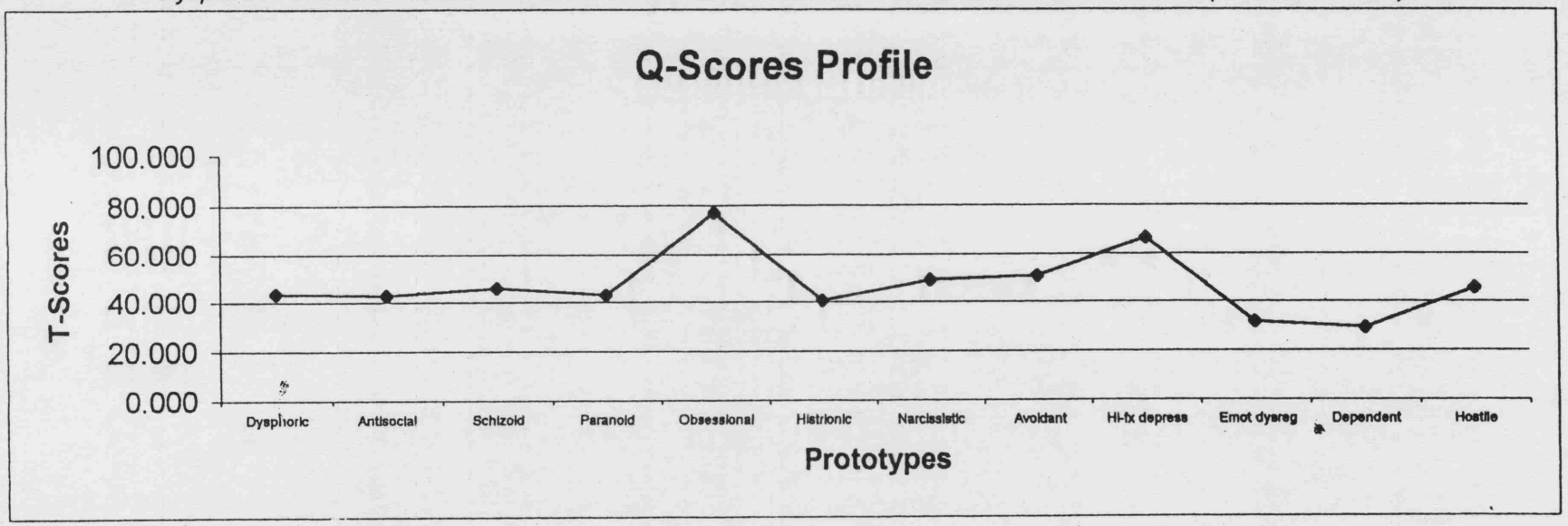
Corr. R1	0.057	-0.065	0.029	0.069	0.687	-0.099	0.010	0.148	0.498	-0.191	-0.306	0.175	0.617
Corr. R2	0.161	-0.083	-0.028	-0.047	0.757	-0.059	0.034	0.213	0.585	-0.211	-0.244	0.085	0.736
Corr. Av	**0.117**	**-0.080**	**0.001**	**0.012**	**0.774**	**-0.085**	**0.024**	**0.194**	**0.581**	**-0.215**	**-0.295**	**0.140**	**0.726**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13)= 0.979 **Hi-fx= 0.726** **verage Corr= 0.109** **SD(corr)= 0.301** **Normality1= 0.840** **Normality2= -0.978**

Average T scores (Q1-Q7)= 48.738 **SD(T-scores) 12.725** **Average T scores (Q1a-Q1 44.662** **SD(T-scores) 15.243**

T-scores	**43.461**	**42.592**	**45.673**	**42.893**	**76.923**	**40.500**	**49.126**	**50.645**	**66.528**	**31.577**	**29.058**	**45.503**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



732

Westenv2rater(1)

Correlations between sort for this subject and Q-score norms

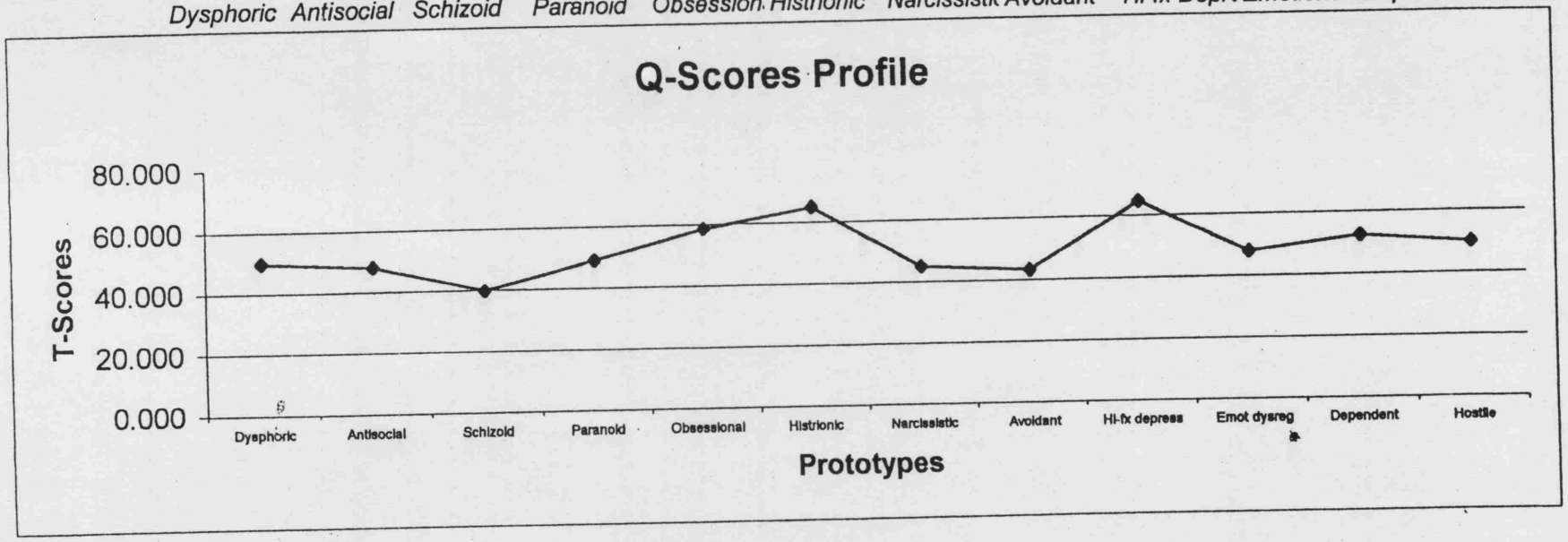
Corr. R1	0.287	0.026	-0.131	0.115	0.389	0.302	-0.084	0.001	0.544	0.090	0.122	0.193	0.455
Corr. R2	0.244	0.074	-0.136	0.134	0.271	0.300	0.019	-0.050	0.465	0.119	0.111	0.211	0.401
Corr. Av	**0.275**	**0.052**	**-0.139**	**0.129**	**0.342**	**0.312**	**-0.033**	**-0.025**	**0.524**	**0.108**	**0.121**	**0.210**	**0.444**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13)= 0.966 HI-fx= 0.444 verage Corr= 0.134 SD(corr)= 0.184 Normality1= 0.668 Normality2= -0.932

Average T scores (Q1-Q7)= 50.588 SD(T-scores) 8.324 Average T scores (Q1a-Q1 51.473 SD(T-scores) 7.958

T-scores	**49.579**	**48.032**	**39.810**	**48.982**	**58.376**	**64.555**	**44.779**	**43.038**	**64.314**	**47.762**	**52.405**	**49.846**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



007c

733

Westenv2rater(1)

Correlations between sort for this subject and Q-score norms

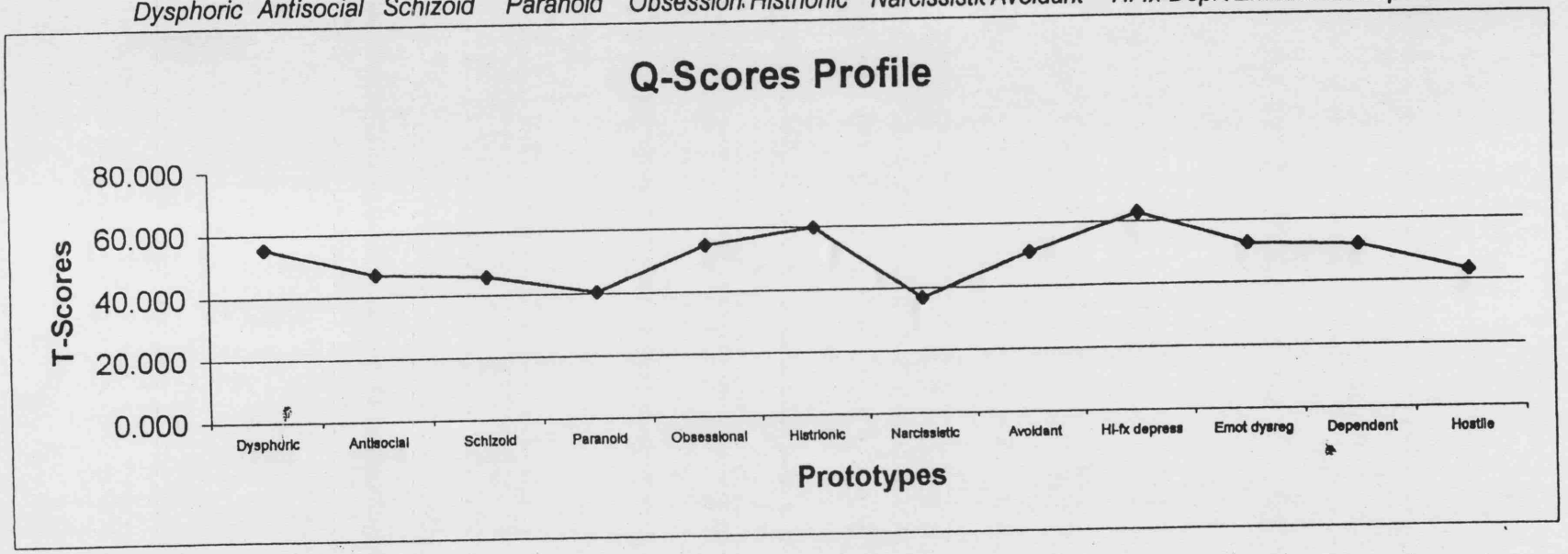
Corr. R1	0.389	0.012	-0.050	-0.003	0.254	0.227	-0.110	0.142	0.494	0.194	0.076	0.096	0.390
Corr. R2	0.423	0.035	0.052	-0.071	0.233	0.210	-0.157	0.232	0.420	0.188	0.129	0.101	0.331
Corr. Av	**0.425**	**0.024**	**0.001**	**-0.038**	**0.254**	**0.228**	**-0.139**	**0.195**	**0.477**	**0.200**	**0.107**	**0.103**	**0.377**

Agreement between raters in their correlations with Q-scores Profile and T-scores

teliability (13) 0.948 **Hi-fx= 0.377** **verage Corr= 0.108** **SD(corr)= 0.199** **Normality1= 0.686** **Normality2= -0.928**

Average T scores (Q1-Q7)= 48.430 **SD(T-scores) 8.381** **Average T scores (Q1a-Q1 52.086** **SD(T-scores) 6.889**

T-scores	**55.350**	**46.904**	**45.691**	**40.291**	**54.607**	**59.467**	**36.701**	**50.702**	**62.528**	**52.341**	**51.637**	**43.219**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



009c

Westenv2rater(1)

Correlations between sort for this subject and Q-score norms

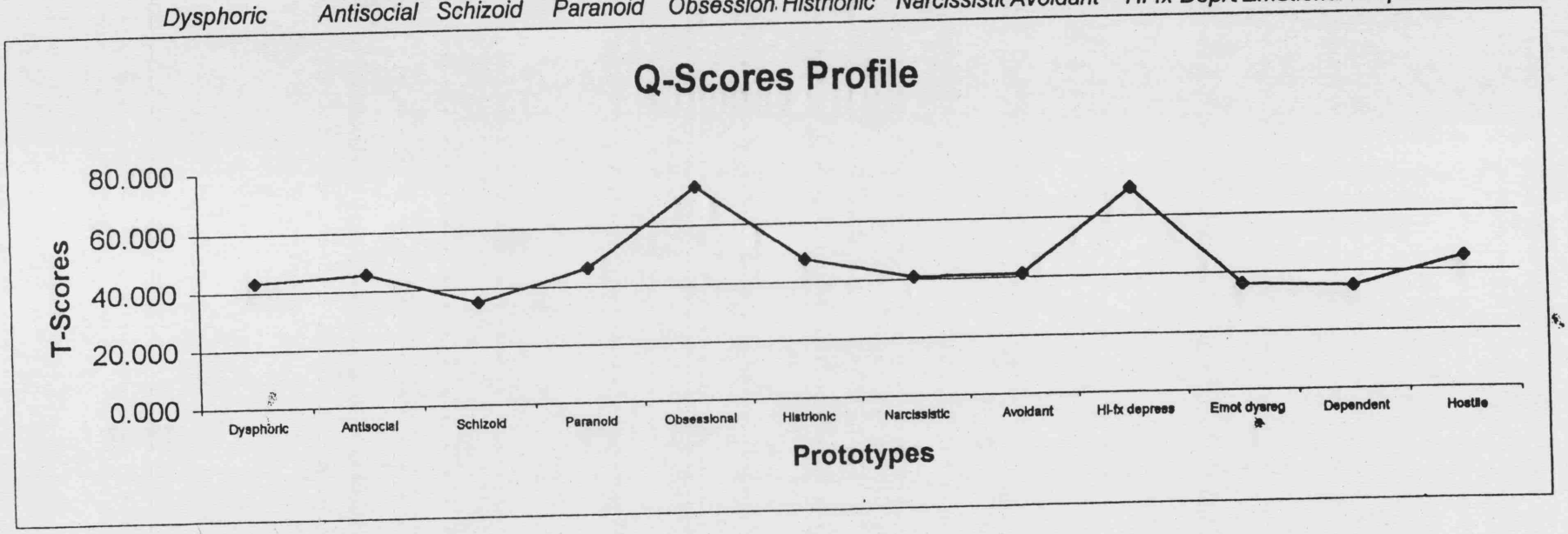
Corr. R1	0.067	-0.014	-0.241	0.025	0.646	-0.009	-0.028	-0.068	0.614	-0.160	-0.213	0.058
Corr. R2	0.143	0.005	-0.229	0.121	0.642	0.072	-0.136	-0.087	0.617	-0.073	-0.145	0.180
Corr. Av	**0.110**	**-0.005**	**-0.246**	**0.076**	**0.674**	**0.033**	**-0.086**	**-0.081**	**0.644**	**-0.122**	**-0.187**	**0.124**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13)= 0.979 **Hi-fx= 0.763** **verage Corr= 0.079** **SD(corr)= 0.288** **Normality1= 0.891** **Normality2= -0.848**

Average T scores (Q1-Q7)= 47.344 **SD(T-scores) 11.892** **Average T scores (Q1a-Q1 45.193** **SD(T-scores) 13.818**

T-scores	**43.186**	**45.693**	**35.285**	**46.232**	**72.615**	**47.623**	**40.774**	**41.105**	**68.955**	**36.232**	**35.107**	**44.565**
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*



11c

Westenv2rater(1)
Profile 11

0.759
0.699
0.763

Hi-fx

Westenv2rater(1)

Correlations between sort for this subject and Q-score norms

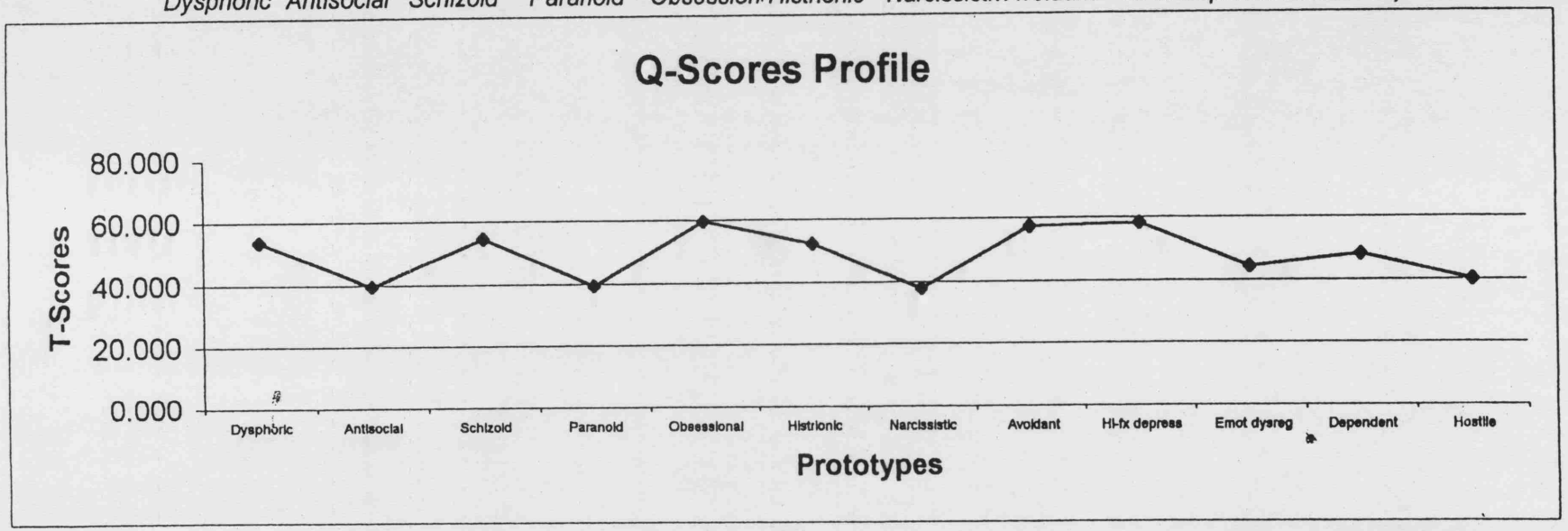
Corr. R1	0.294	-0.158	0.221	-0.063	0.331	0.059	-0.093	0.357	0.277	-0.011	-0.013	0.035	0.379
Corr. R2	0.404	-0.124	0.158	-0.043	0.334	0.139	-0.138	0.334	0.387	0.077	0.090	0.056	0.365
Corr. Av	**0.381**	**-0.154**	**0.207**	**-0.058**	**0.363**	**0.109**	**-0.126**	**0.377**	**0.363**	**0.036**	**0.042**	**0.050**	**0.406**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13)= 0.946 **Hi-fx= 0.406** **verage Corr= 0.103** **SD(corr)= 0.224** **Normality1= 0.724** **Normality2= -0.863**

Average T scores (Q1-Q7)= 47.992 **SD(T-scores) 8.863** **Average T scores (Q1a-Q1 49.433** **SD(T-scores) 7.960**

T-scores	**53.663**	**39.513**	**54.320**	**39.257**	**59.272**	**52.214**	**37.702**	**57.026**	**58.100**	**44.130**	**47.988**	**39.921**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



737

Westenv2rater(1)

Correlations between sort for this subject and Q-score norms

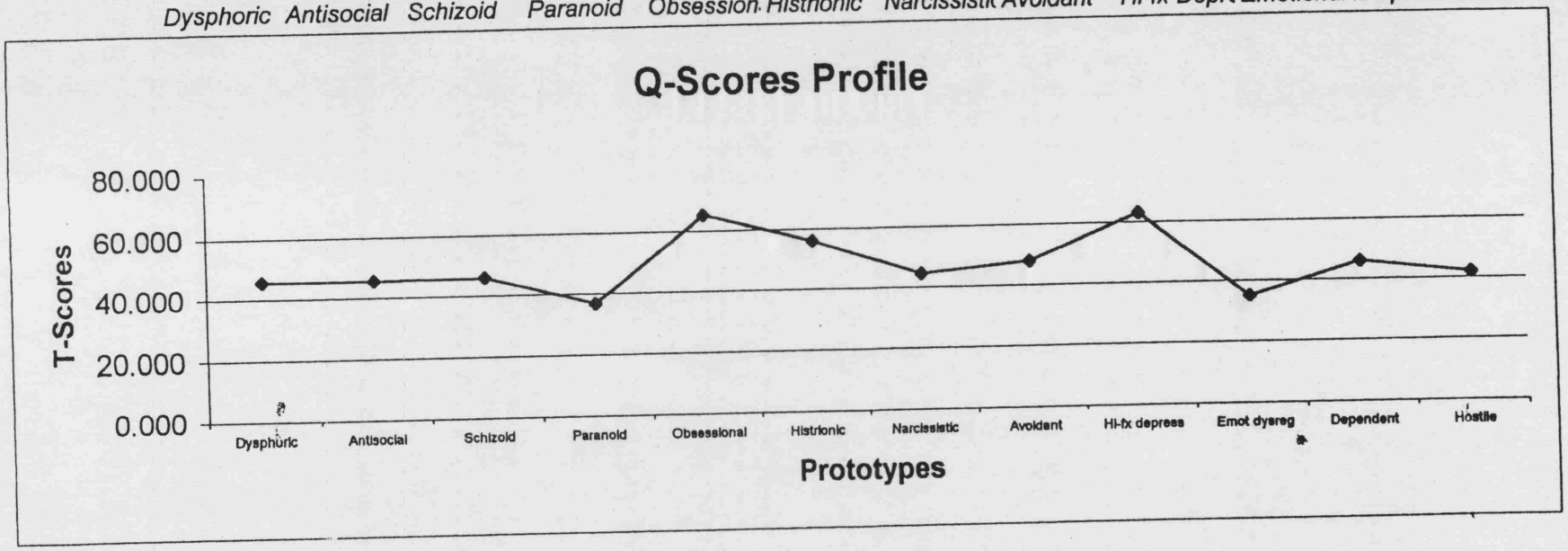
Corr. R1	0.105	0.047	0.033	-0.052	0.456	0.119	-0.023	0.075	0.399	-0.155	-0.029	0.157	0.478
Corr. R2	0.204	-0.064	-0.025	-0.152	0.460	0.193	-0.049	0.130	0.506	-0.122	0.035	-0.006	0.582
Corr. Av	**0.167**	**-0.010**	**0.005**	**-0.110**	**0.496**	**0.169**	**-0.039**	**0.111**	**0.490**	**-0.150**	**0.003**	**0.082**	**0.573**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13)= 0.945 Hi-fx= 0.573 verage Corr= 0.097 SD(corr)= 0.204 Normality1= 0.820 Normality2= -0.954

Average T scores (Q1-Q7)= 48.359 SD(T-scores) 9.220 Average T scores (Q1a-Q1 46.668 SD(T-scores) 10.376

T-scores	**45.414**	**45.498**	**45.823**	**36.576**	**64.961**	**55.869**	**44.374**	**47.782**	**62.995**	**34.855**	**45.785**	**41.923**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



Correlations between sort for this subject and Q-score norms

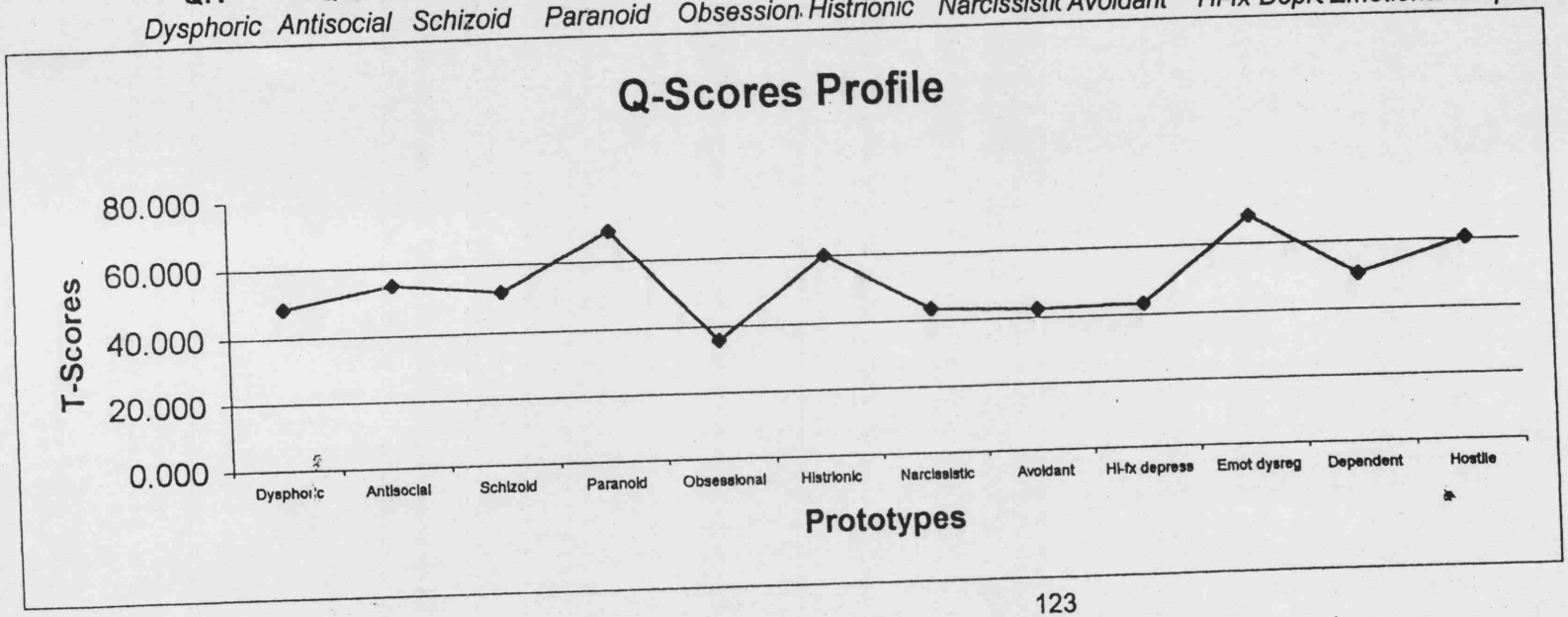
Corr. R1	0.228	0.140	0.050	0.485	-0.160	0.258	-0.080	-0.101	0.037	0.506	0.106	0.275	-0.125
Corr. R2	0.215	0.252	0.228	0.451	-0.173	0.174	-0.017	0.019	-0.088	0.432	0.052	0.416	-0.178
Corr. Av	0.243	0.215	0.153	0.514	-0.183	0.237	-0.054	-0.045	-0.028	0.515	0.087	0.379	-0.166

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13) 0.899 **Hi-fx= -0.166** **Average Corr= 0.169** **SD(corr)= 0.226** **Normality1= -94.405** **Normality2= -0.916**

Average T scores= 52.296 **SD(T-scores) 10.495**

T-scores	**48.356**	**54.814**	**52.042**	**68.890**	**35.857**	**60.002**	**43.238**	**42.358**	**43.022**	**68.087**	**50.507**	**60.380**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional .*	*Dependent*	*Hostile*	*Hi-fx*

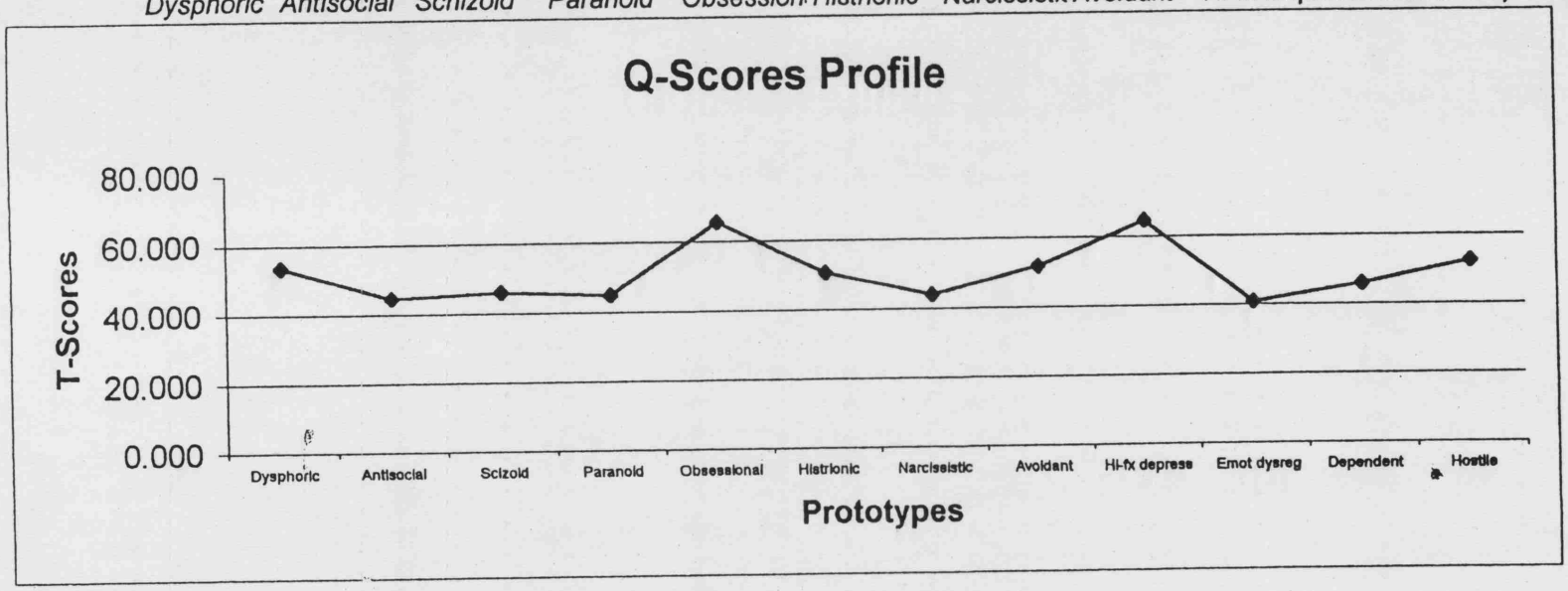


Correlations between sort for this subject and Q-score norms

Corr. R1	0.416	-0.053	0.017	0.015	0.472	0.108	-0.048	0.248	0.561	0.013	0.030	0.172	0.544
Corr. R2	-0.006	-0.092	-0.014	-0.049	-0.025	-0.095	0.039	0.021	0.015	-0.086	-0.031	-0.016	0.012
Corr. R2	0.284	-0.011	-0.005	0.075	0.477	0.041	-0.035	0.167	0.424	-0.078	-0.030	0.287	0.507
Corr. Av	**0.375**	**-0.034**	**0.007**	**0.048**	**0.509**	**0.080**	**-0.045**	**0.222**	**0.528**	**-0.035**	**0.000**	**0.246**	**0.563**

Agreement between raters in their correlations with Q-score Profile and T-scores

Reliability	R1vR2= 0.397		R1vR3= 0.931		R2vR3= 0.390		Mean (R)= 0.573		Hi-fx= 0.563				
Average Cori 0.158		SD(corr)= 0.213		Normality1= 0.692		Normality2= -0.170		Average T(Q 49.785		SD (Tscore)= 7.799		Average T(Q 50.889	
T-scores	**53.435**	**44.475**	**45.904**	**44.765**	**65.537**	**50.473**	**43.907**	**51.644**	**64.475**	**40.612**	**45.606**	**52.108**	SD (Tscore)=
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	8.947
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



740

Correlations between sort for this subject and Q-score norms

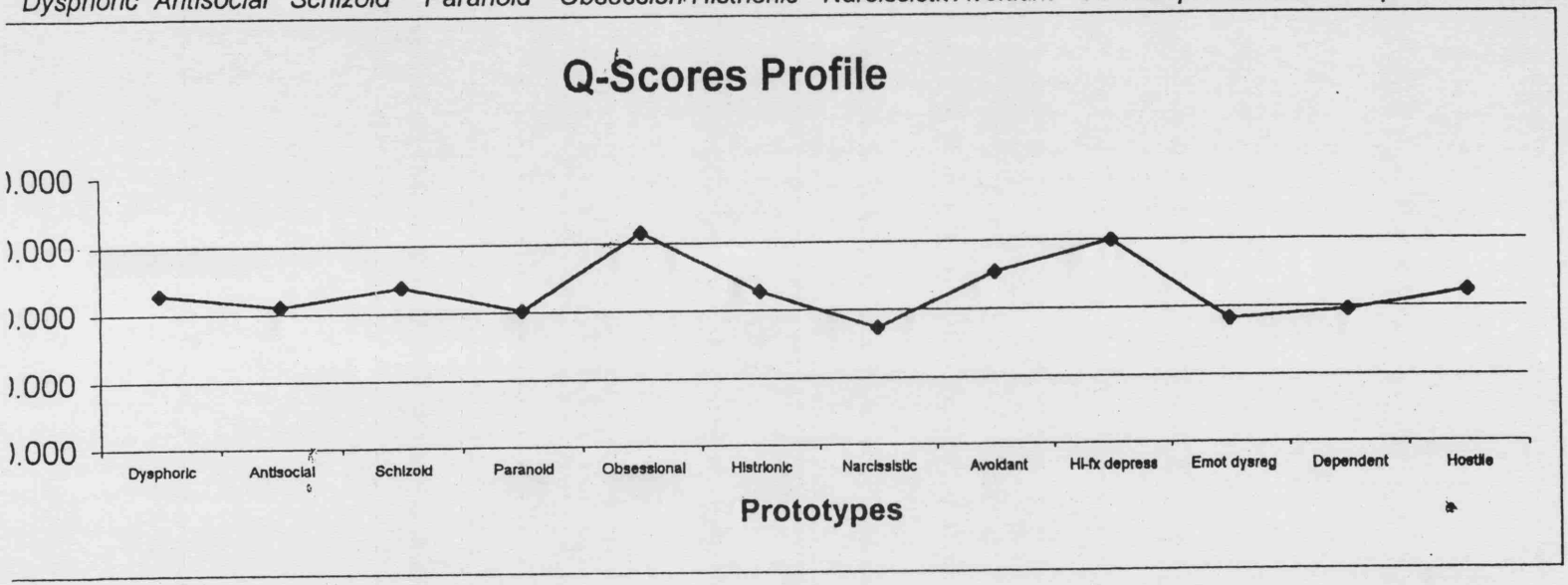
0.088	-0.108	0.005	-0.020	0.448	-0.026	-0.198	0.122	0.379	-0.161	-0.153	0.112	0.542
0.239	-0.063	0.079	-0.050	0.392	0.020	-0.119	0.239	0.380	-0.058	-0.069	0.122	0.490
0.175	**-0.091**	**0.045**	**-0.038**	**0.449**	**-0.003**	**-0.169**	**0.193**	**0.405**	**-0.117**	**-0.119**	**0.125**	**0.552**

Agreement between raters in their correlations with Q-scores Profile and T-scores

0.958 Hi-fx= 0.552 verage Corr= 0.053 SD(corr)= 0.205 Normality1= 0.901 Normality2= -0.825

ores (Q1-Q7)= 45.499 SD(T-scores) 8.853 Average T scores (Q1a-Q1 46.086 SD(T-scores) 9.387

45.710	**42.098**	**47.528**	**40.333**	**62.964**	**45.446**	**34.417**	**50.632**	**59.744**	**36.491**	**38.938**	**44.626**	
Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



Westenv2rater

Correlations between sort for this subject and Q-score norms

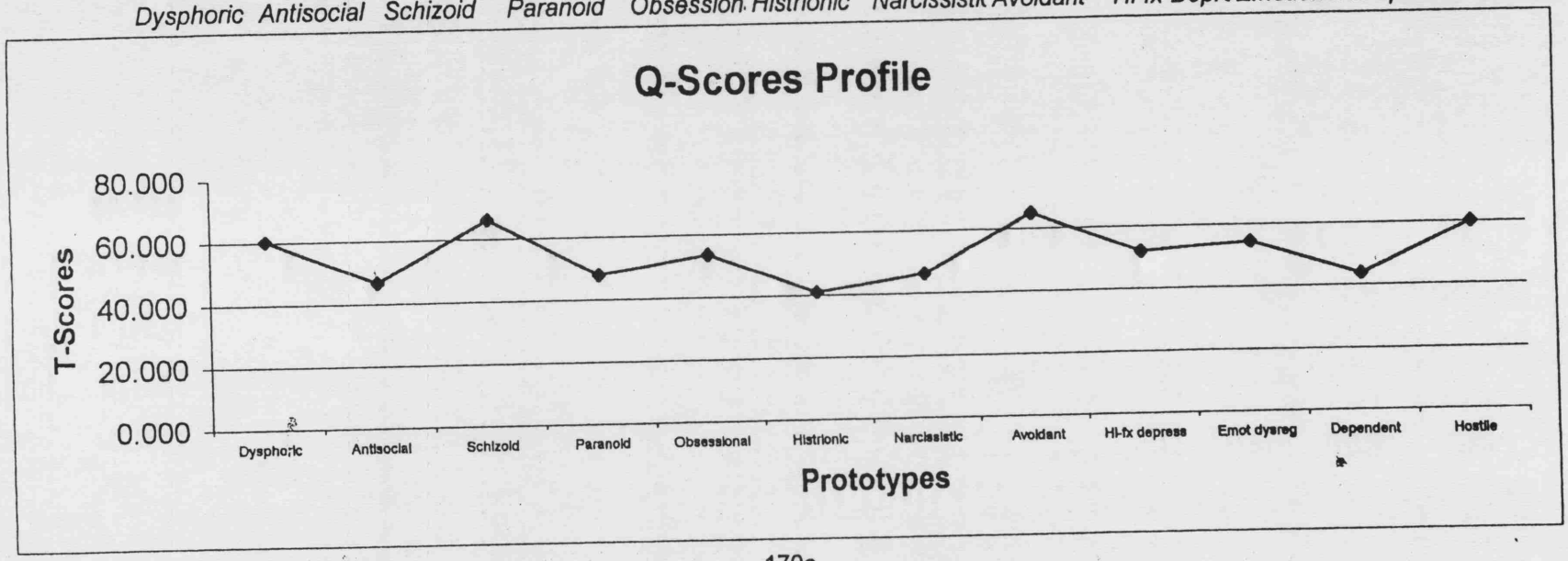
Corr. R1	0.538	0.041	0.474	0.149	0.194	-0.082	-0.046	0.566	0.183	0.265	-0.039	0.400	0.107
Corr. R2	0.521	-0.010	0.465	0.057	0.243	-0.068	0.012	0.590	0.198	0.195	-0.032	0.320	0.202
Corr. Av	**0.547**	**0.016**	**0.486**	**0.107**	**0.226**	**-0.077**	**-0.018**	**0.598**	**0.197**	**0.238**	**-0.037**	**0.372**	**0.160**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13) 0.980 **Hi-fx= 0.160** **Average Corr= 0.184** **SD(corr)= 0.248** **Normality1= -0.098** **Normality2= -0.989**

Average T scores (Q1-Q7)= 51.540 **SD(T-scores) 8.834** **Average T scores (Q1a-Q1 54.820** **SD(T-scores) 8.069**

T-scores	**60.082**	**46.551**	**66.030**	**47.807**	**53.382**	**40.949**	**45.976**	**64.677**	**51.692**	**54.228**	**43.557**	**59.944**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



170c

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Correlations between sort for this subject and Q-score norms

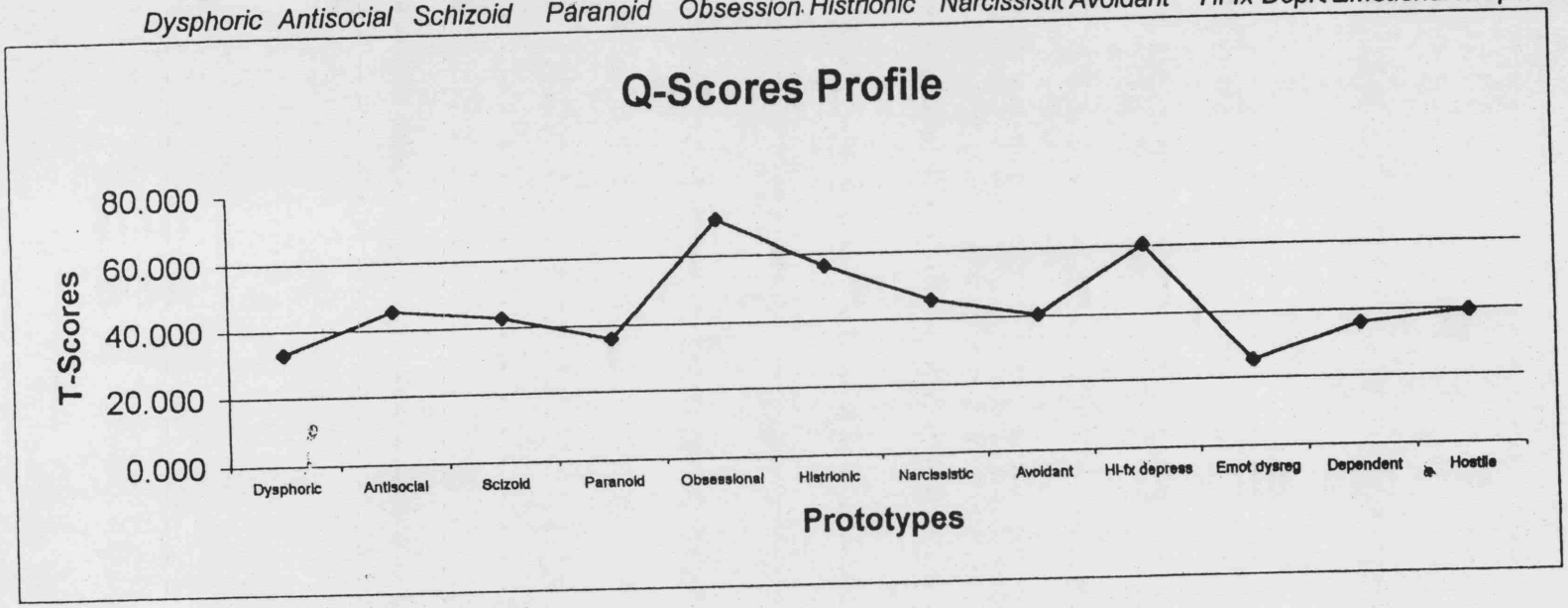
Corr. R1	-0.140	-0.001	-0.204	-0.121	0.595	0.183	-0.005	-0.180	0.504	-0.315	-0.169	0.032	0.716
Corr. R2	0.117	0.051	0.024	-0.043	-0.114	0.081	0.011	0.064	-0.019	0.036	0.188	-0.009	-0.019
Corr. R2	-0.157	-0.023	0.081	-0.107	0.552	0.139	-0.041	-0.010	0.268	-0.310	-0.148	0.044	0.524
Corr. Av	**-0.162**	**-0.013**	**-0.067**	**-0.124**	**0.627**	**0.176**	**-0.025**	**-0.104**	**0.422**	**-0.342**	**-0.173**	**0.042**	**0.677**

Agreement between raters in their correlations with Q-score Profile and T-scores

Reliability R1vR2= -0.575 R1vR3= 0.904 R2vR3= -0.620 Mean (R)= -0.097 HI-fx= 0.677

Average Cori 0.021 SD(corr)= 0.270 Normality1= 0.968 Normality2= 0.125 Average T(Q· 46.996 SD (Tscore)= 12.877 Average T(Q· 40.252

T-scores	**32.688**	**45.351**	**42.819**	**35.834**	**70.587**	**56.288**	**45.406**	**40.328**	**60.379**	**25.257**	**35.877**	**39.420**	SD (Tscore)=
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	12.745
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional .*	*Dependent*	*Hostile*	*Hi-fx*



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Profile 172

Correlations between sort for this subject and Q-score norms

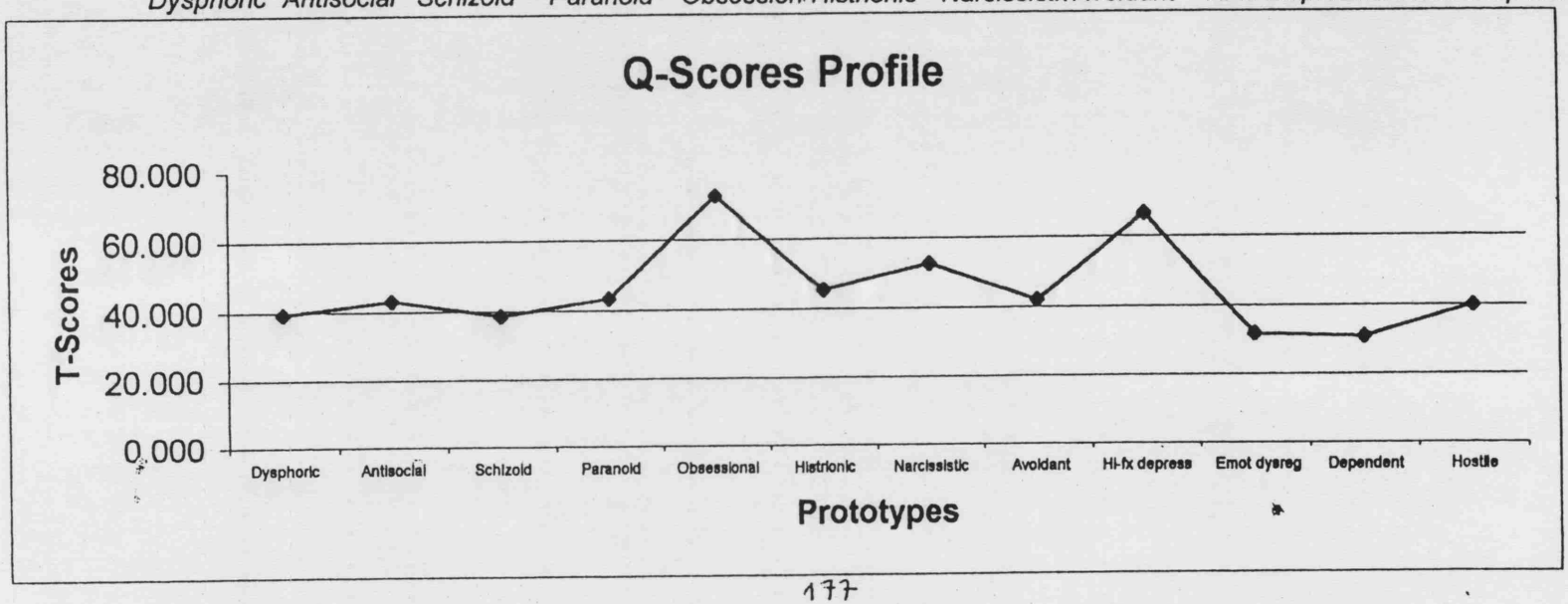
Corr. R1	0.041	-0.131	-0.229	-0.048	0.603	0.020	-0.018	-0.059	0.612	-0.167	-0.223	-0.104
Corr. R2	-0.029	-0.003	-0.094	0.082	0.656	-0.027	0.149	-0.048	0.471	-0.238	-0.275	0.193
Corr. Av	0.006	-0.072	-0.172	0.018	0.672	-0.004	0.070	-0.057	0.578	-0.216	-0.266	0.048

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13) 0.934 Hi-fx= 0.752 verage Corr= 0.050 SD(corr)= 0.289 Normality1= 0.874 Normality2= -0.048

Average T scores= 45.393 SD(T-scores) 12.725

T-scores	**39.196**	**42.916**	**38.392**	**43.201**	**72.532**	**45.418**	**52.679**	**41.957**	**66.407**	**31.544**	**30.672**	**39.808**
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*



177

744

Profile 177

0.756
0.653
0.752

Hi-fx

Profiles208

Correlations between sort for this subject and Q-score norms

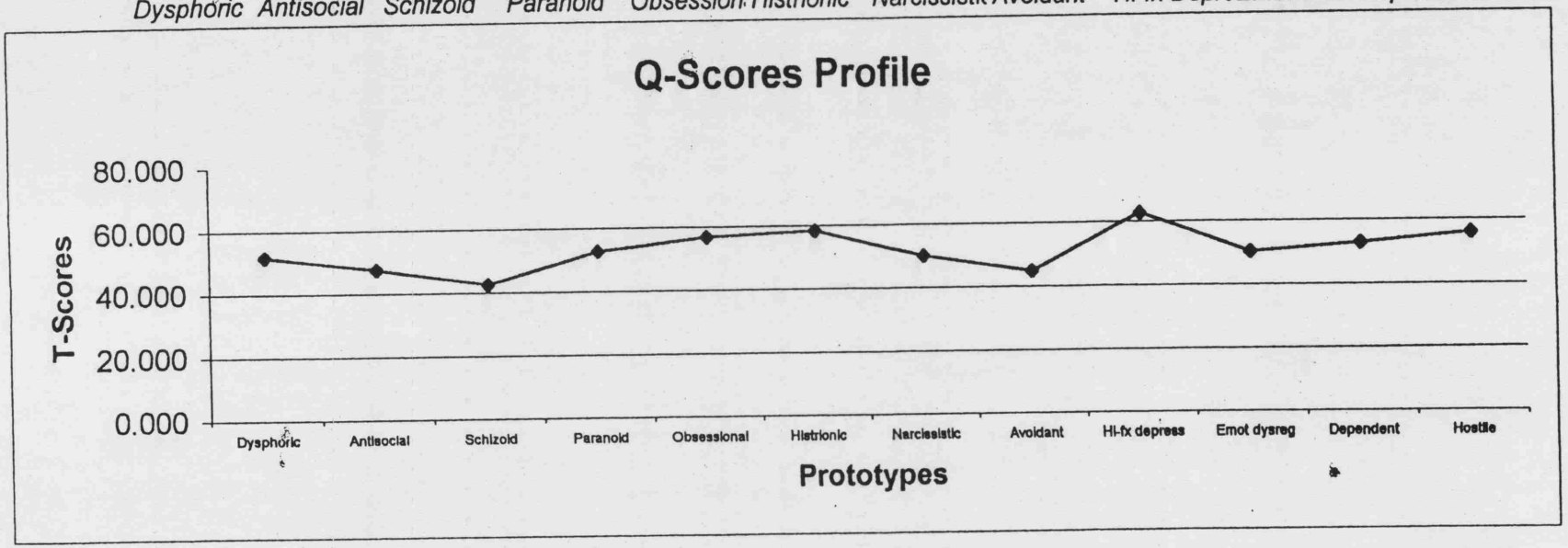
Corr. R1	0.313	-0.024	-0.056	0.175	0.307	0.196	0.040	0.055	0.491	0.137	0.108	0.232	0.356
Corr. R2	0.328	0.106	-0.090	0.213	0.276	0.205	0.028	0.001	0.434	0.170	0.136	0.358	0.288
Corr. Av	**0.332**	**0.042**	**-0.076**	**0.201**	**0.302**	**0.207**	**0.035**	**0.029**	**0.479**	**0.159**	**0.126**	**0.305**	**0.333**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13) 0.944 **HI-fx= 0.333** **Average Corr= 0.149** **SD(corr)= 0.152** **Normality1= 0.505** **Normality2= -0.980**

Average T scores (Q1-Q7)= 51.347 **SD(T-scores) 5.350** **Average T scores (Q1a-Q1 53.267** **SD(T-scores) 6.557**

T-scores	**51.773**	**47.638**	**42.448**	**52.689**	**56.643**	**58.202**	**50.032**	**44.925**	**62.589**	**50.312**	**52.704**	**55.803**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



Profiles210c

Correlations between sort for this subject and Q-score norms

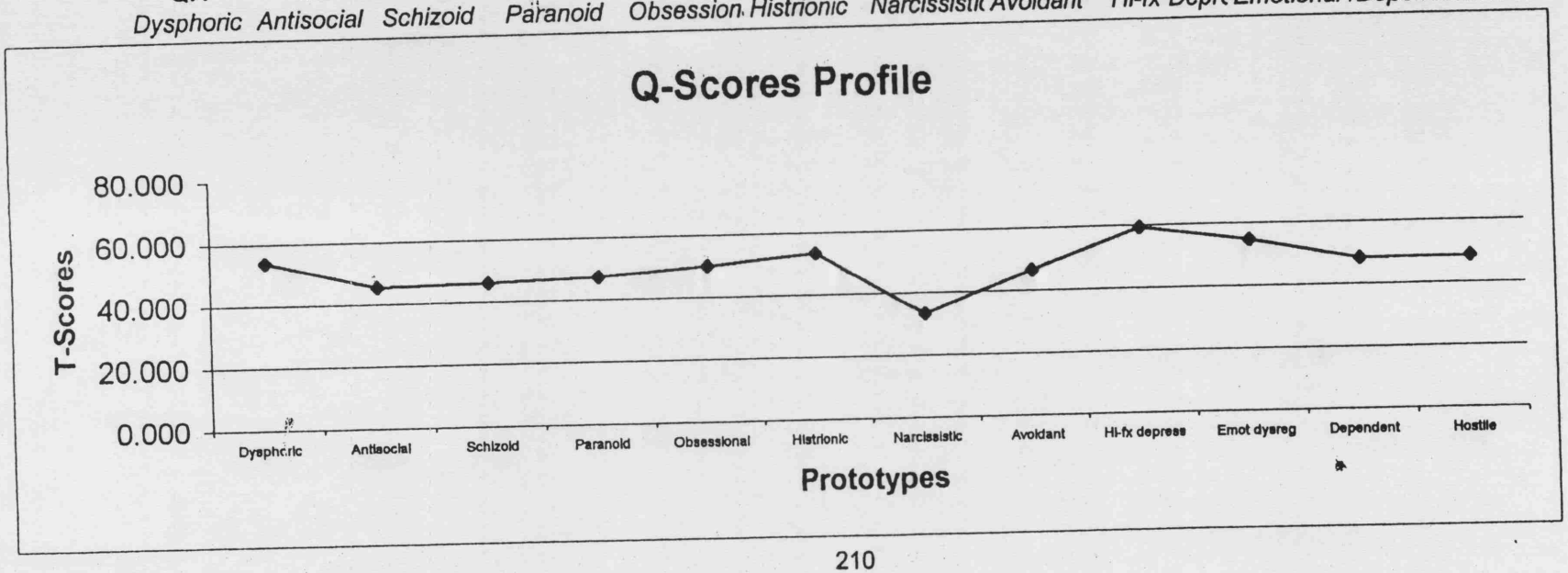
Corr. R1	0.366	-0.008	0.031	0.170	0.068	0.088	-0.134	0.054	0.313	0.285	0.015	0.257	0.202
Corr. R2	0.337	-0.021	-0.014	0.004	0.197	0.145	-0.211	0.079	0.408	0.172	0.071	0.095	0.350
Corr. Av	**0.378**	**-0.015**	**0.009**	**0.094**	**0.142**	**0.126**	**-0.186**	**0.072**	**0.388**	**0.246**	**0.046**	**0.189**	**0.298**

Agreement between raters in their correlations with Q-scores Profile and T-scores

tellability (13) 0.855 **Hi-fx= 0.298** **verage Corr= 0.078** **SD(corr)= 0.173** **Normality1= 0.713** **Normality2= -0.802**

Average T scores (Q1-Q7)= 46.885 **SD(T-scores)** **6.896** **Average T scores (Q1a-Q1 51.392** **SD(T-scores)** **5.297**

T-scores	**53.564**	**45.251**	**46.012**	**47.153**	**49.807**	**53.243**	**33.164**	**46.414**	**59.073**	**54.650**	**48.225**	**48.596**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



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Profiles253

Correlations between sort for this subject and Q-score norms

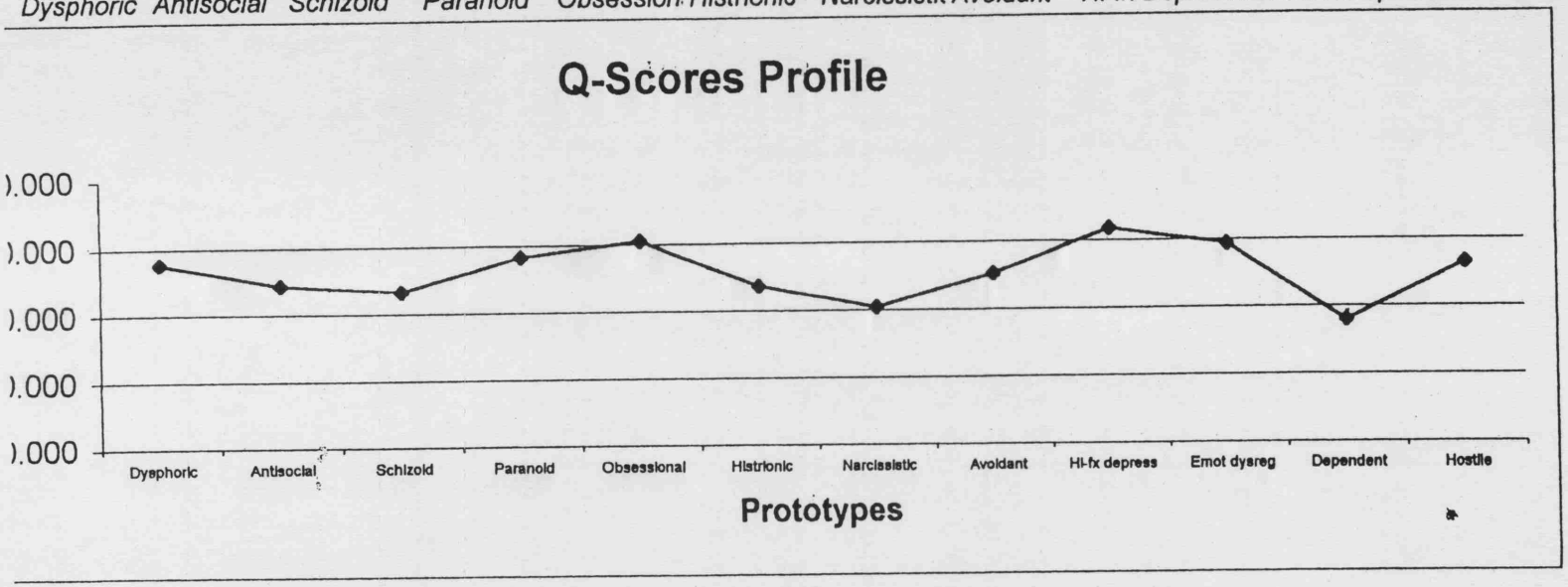
0.360	0.050	-0.100	0.275	0.455	0.050	-0.092	0.066	0.582	0.263	-0.174	0.231	0.455
0.418	0.066	0.134	0.233	0.286	-0.004	-0.066	0.284	0.335	0.332	-0.146	0.244	0.267
0.422	**0.063**	**0.018**	**0.276**	**0.402**	**0.025**	**-0.086**	**0.190**	**0.498**	**0.323**	**-0.174**	**0.258**	**0.392**

Agreement between raters in their correlations with Q-scores Profile and T-scores

0.816 HI-fx= 0.392 verage Corr= 0.160 SD(corr)= 0.204 Normality1= 0.548 Normality2= -0.982

:ores (Q1-Q7)= 50.794 SD(T-scores) 7.011 Average T scores (Q1a-Q1 52.203 SD(T-scores) 10.409

55.255	**48.492**	**46.394**	**56.561**	**60.944**	**47.159**	**40.750**	**50.513**	**63.302**	**58.500**	**35.854**	**52.846**	
Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



748

Profiles337

Correlations between sort for this subject and Q-score norms

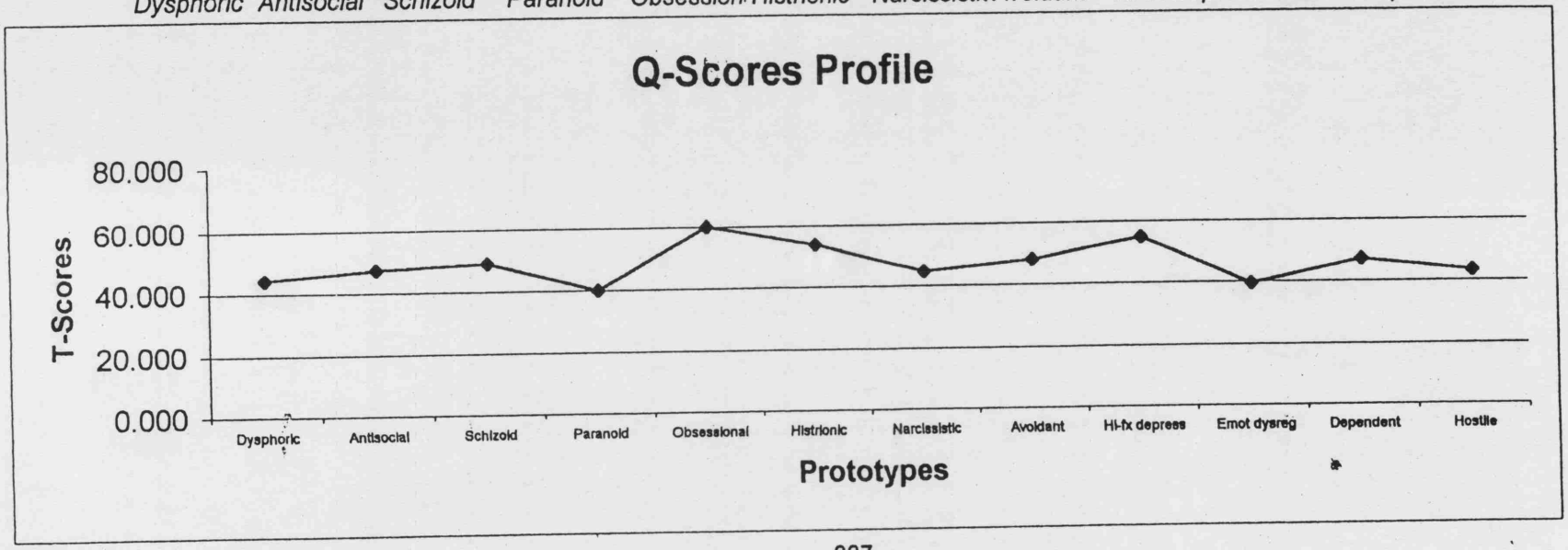
Corr. R1	0.128	0.029	0.067	-0.056	0.361	0.157	-0.038	0.098	0.274	-0.059	0.042	0.087
Corr. R2	0.146	0.034	0.086	-0.042	0.389	0.105	-0.034	0.129	0.279	-0.057	0.008	0.115
Corr. Av	**0.137**	**0.032**	**0.077**	**-0.049**	**0.377**	**0.131**	**-0.036**	**0.114**	**0.278**	**-0.058**	**0.025**	**0.102**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13) 0.984 **Hi-fx= 0.367** **Average Corr= 0.096** **SD(corr)= 0.144** **Normality1= 0.716** **Normality2= -0.980**

Average T scores (Q1-Q7)= 48.303 **SD(T-scores) 6.676** **Average T scores (Q1a-Q1 46.462** **SD(T-scores) 5.761**

T-scores	**44.262**	**47.206**	**48.878**	**39.728**	**59.878**	**53.602**	**44.571**	**47.888**	**54.821**	**39.429**	**47.035**	**43.139**
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*



Correlations between sort for this subject and Q-score norms

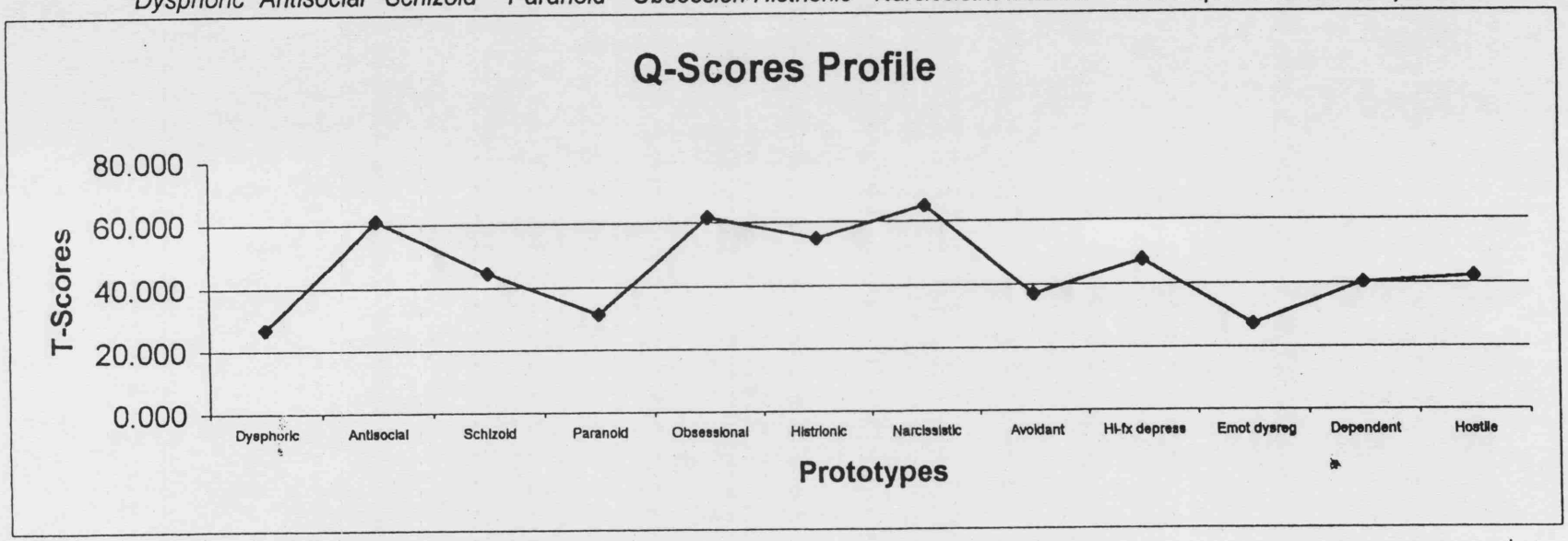
Corr. R1	-0.298	0.411	-0.011	-0.196	0.373	0.061	0.163	-0.189	0.061	-0.267	-0.128	0.110	0.298
Corr. R2	-0.290	0.265	-0.037	-0.198	0.401	0.215	0.262	-0.185	0.106	-0.302	-0.054	0.048	0.330
Corr. Av	**-0.315**	**0.362**	**-0.026**	**-0.211**	**0.414**	**0.148**	**0.228**	**-0.200**	**0.089**	**-0.305**	**-0.098**	**0.085**	**0.336**

Agreement between raters in their correlations with Q-scores Profile and T-scores

teliability (13) 0.948 Hi-fx= 0.336 verage Corr= 0.086 SD(corr)= 0.280 Normality1= 0.722 Normality2= -0.576

Average T scores (Q1-Q7)= 49.197 SD(T-scores) 15.272 Average T scores (Q1a-Q1 38.773 SD(T-scores) 7.561

T-scores	**26.795**	**60.912**	**44.551**	**31.351**	**61.479**	**54.590**	**64.703**	**36.975**	**47.534**	**27.123**	**40.128**	**42.106**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



750

Profiles390

Correlations between sort for this subject and Q-score norms

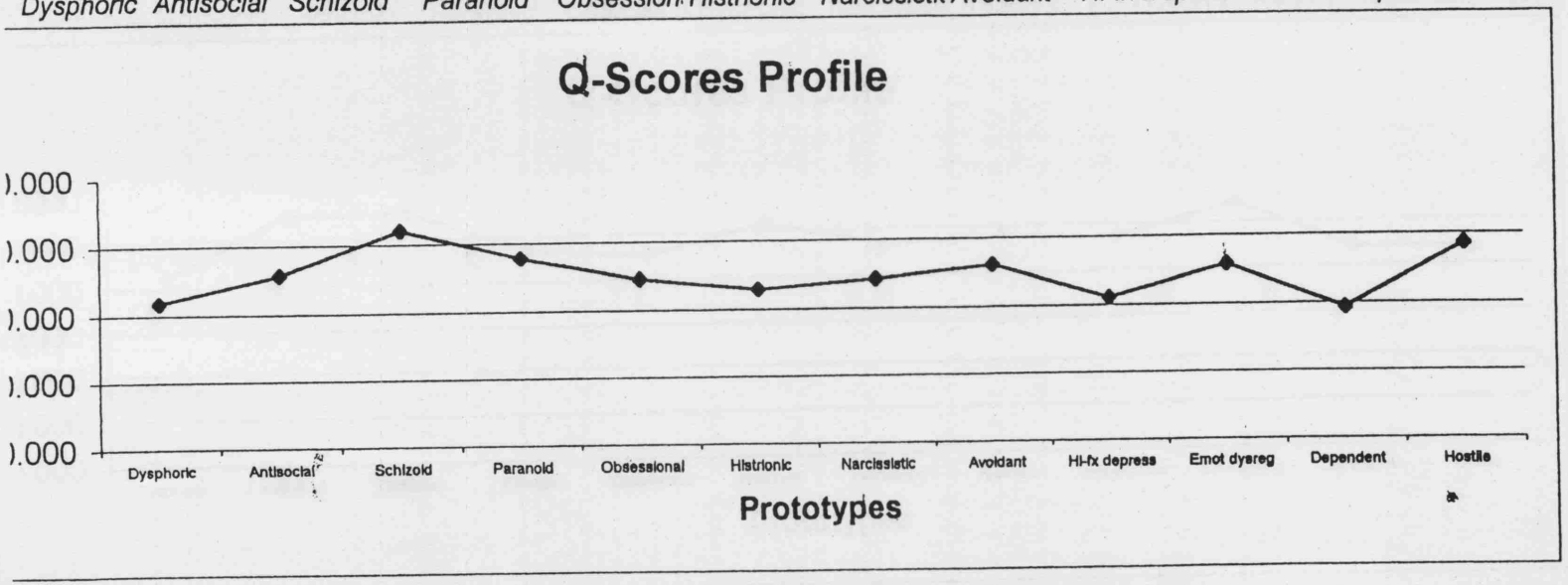
0.046	0.142	0.450	0.254	0.097	-0.017	0.032	0.219	-0.147	0.145	-0.142	0.335	-0.068
0.173	0.097	0.370	0.224	0.133	0.020	-0.008	0.223	0.046	0.195	-0.093	0.284	0.033
0.116	**0.126**	**0.433**	**0.252**	**0.122**	**0.001**	**0.013**	**0.234**	**-0.054**	**0.180**	**-0.124**	**0.327**	**-0.019**

Agreement between raters in their correlations with Q-scores Profile and T-scores

0.903 Hi-fx= -0.019 verage Corr= 0.152 SD(corr)= 0.149 Normality1= -1.115 Normality2= -1.000

:ores (Q1-Q7)= 50.951 SD(T-scores) 6.836 Average T scores (Q1a-Q1(48.233 SD(T-scores) 7.634

43.420	**51.123**	**63.824**	**55.351**	**48.917**	**45.704**	**48.319**	**52.032**	**42.027**	**51.332**	**38.658**	**57.114**
Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**
Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



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Profiles399c

Correlations between sort for this subject and Q-score norms

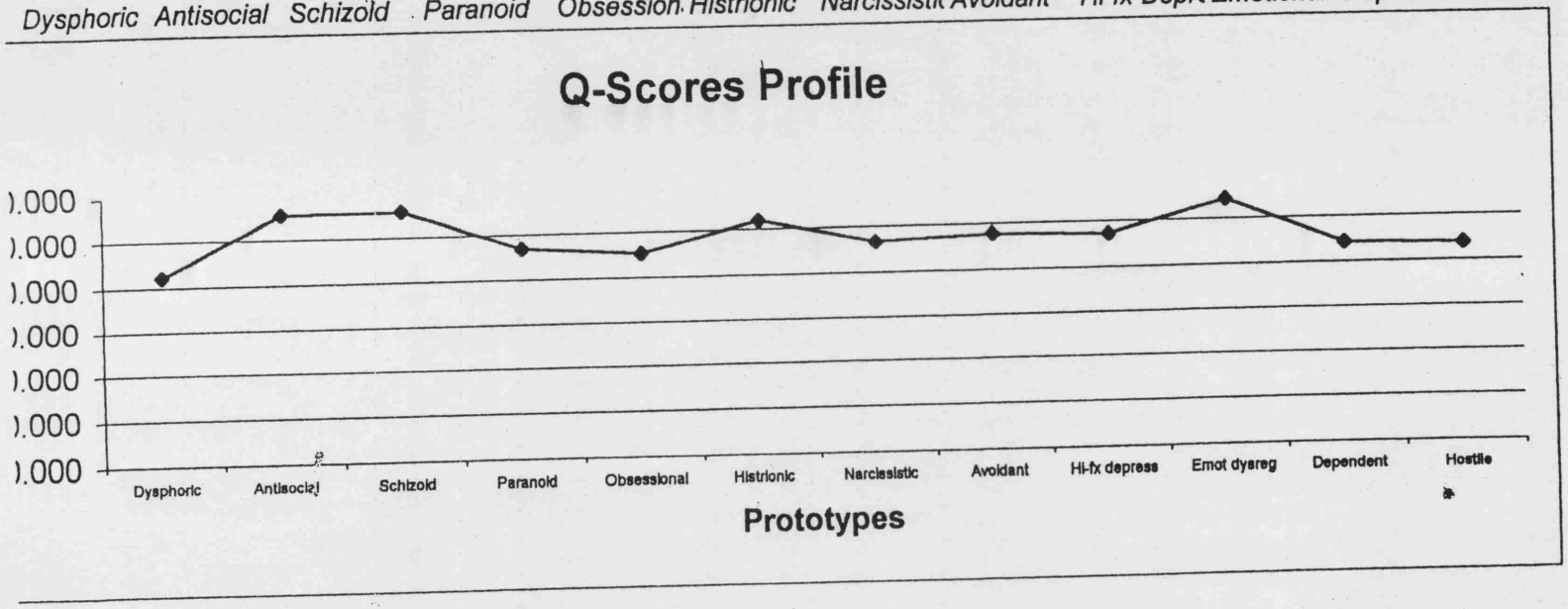
0.093	0.170	0.257	0.134	0.065	0.048	-0.006	0.157	0.102	0.242	-0.072	0.095	0.078
0.055	0.255	0.190	0.026	-0.001	0.143	-0.010	0.053	0.050	0.202	0.023	0.112	0.020
0.079	**0.229**	**0.240**	**0.086**	**0.034**	**0.103**	**-0.008**	**0.113**	**0.081**	**0.238**	**-0.026**	**0.111**	**0.053**

Agreement between raters in their correlations with Q-scores Profile and T-scores

0.678 Hi-fx= 0.053 verage Corr= 0.109 SD(corr)= 0.093 Normality1= -0.466 Normality2= -1.000

ores (Q1-Q7)= 49.084 SD(T-scores) 5.286 Average T scores (Q1a-Q1 47.452 SD(T-scores) 4.222

42.027	**55.382**	**55.706**	**46.743**	**45.158**	**51.868**	**46.706**	**47.841**	**47.238**	**54.274**	**44.156**	**43.751**
Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**
Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



399c

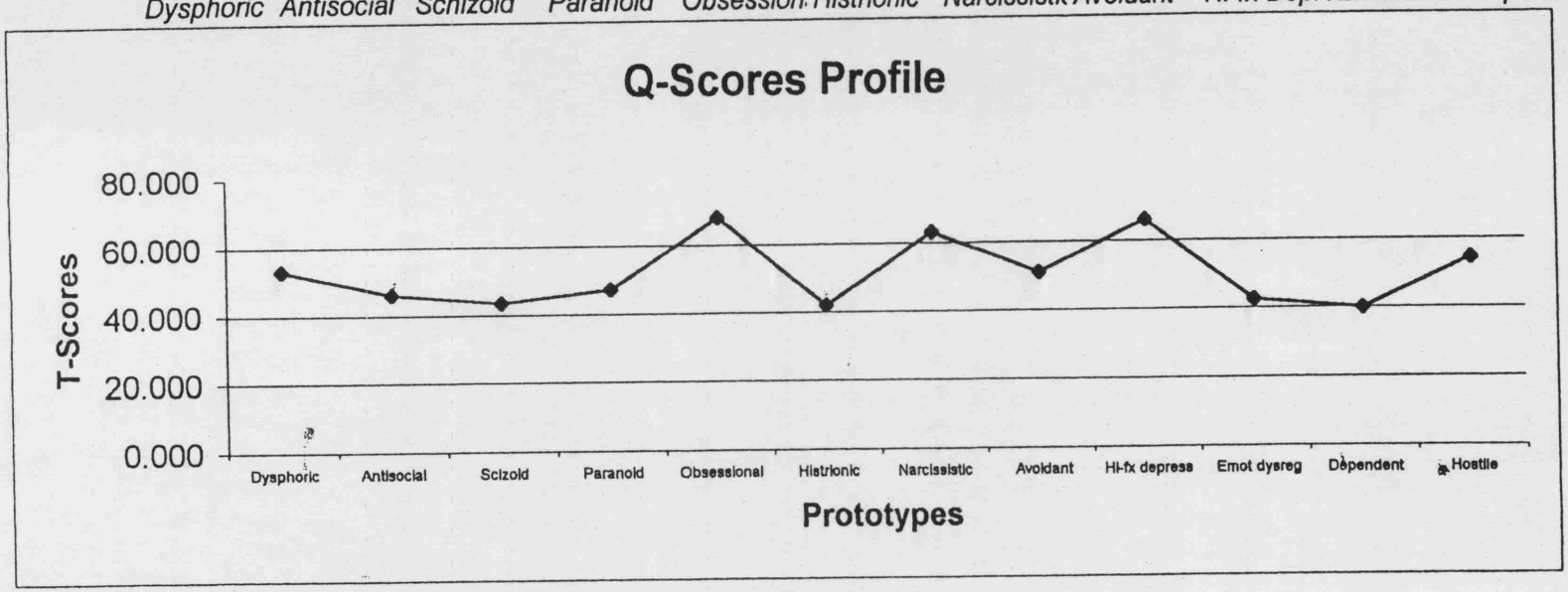
752

Correlations between sort for this subject and Q-score norms

Corr. R1	0.408	-0.056	-0.040	0.060	0.534	-0.011	0.127	0.238	0.602	0.021	-0.060	0.240	0.584
Corr. R2	0.017	-0.046	0.004	-0.042	0.078	0.030	-0.005	0.051	0.088	-0.111	0.052	-0.011	0.062
Corr. R2	0.284	0.062	-0.066	0.112	0.534	-0.111	0.259	0.145	0.472	-0.021	-0.141	0.291	0.516
Corr. Av	**0.367**	**0.003**	**-0.057**	**0.091**	**0.566**	**-0.065**	**0.205**	**0.203**	**0.570**	**0.000**	**-0.107**	**0.282**	**0.583**

Agreement between raters in their correlations with Q-score Profile and T-scores

Reliability	R1vR2= 0.589		R1vR3= 0.921		R2vR3= 0.423		Mean (R)= 0.644		Hi-fx= 0.583				
Average Corr	0.172	SD(corr)= 0.237		Normality1= 0.677		Normality2= -0.258		Average T(Q- 51.727		SD (Tscore)= 10.165		Average T(Q- 50.678	
T-scores	**53.129**	**46.021**	**43.251**	**47.014**	**67.998**	**41.711**	**62.968**	**50.978**	**66.099**	**42.352**	**39.625**	**54.334**	SD (Tscore)=
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	10.521
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



Profiles436

Correlations between sort for this subject and Q-score norms

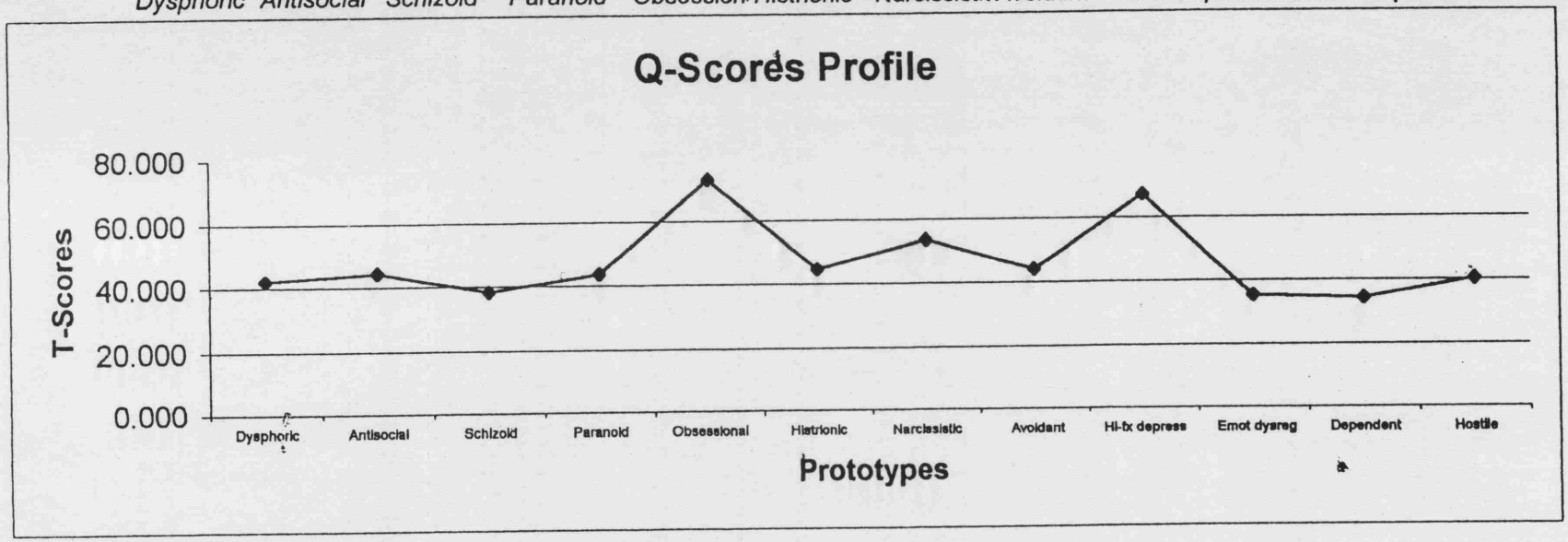
Corr. R1	0.032	-0.011	-0.194	0.030	0.636	-0.026	0.115	-0.051	0.552	-0.146	-0.190	0.043	0.590
Corr. R2	0.122	-0.062	-0.148	0.015	0.649	-0.009	0.037	0.058	0.571	-0.132	-0.199	0.060	0.612
Corr. Av	**0.081**	**-0.038**	**-0.180**	**0.024**	**0.678**	**-0.019**	**0.081**	**0.003**	**0.592**	**-0.147**	**-0.205**	**0.055**	**0.635**

Agreement between raters in their correlations with Q-scores Profile and T-scores

tellability (13) 0.981 HI-fx= 0.635 verage Corr= 0.090 SD(corr)= 0.274 Normality1= 0.851 Normality2= -0.925

Average T scores (Q1-Q7)= 48.393 SD(T-scores) 11.719 Average T scores (Q1a-Q1 44.065 SD(T-scores) 13.422

T-scores	**42.097**	**44.299**	**38.052**	**43.508**	**72.802**	**44.511**	**53.483**	**44.035**	**66.965**	**35.022**	**34.077**	**40.228**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



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Profiles454

Correlations between sort for this subject and Q-score norms

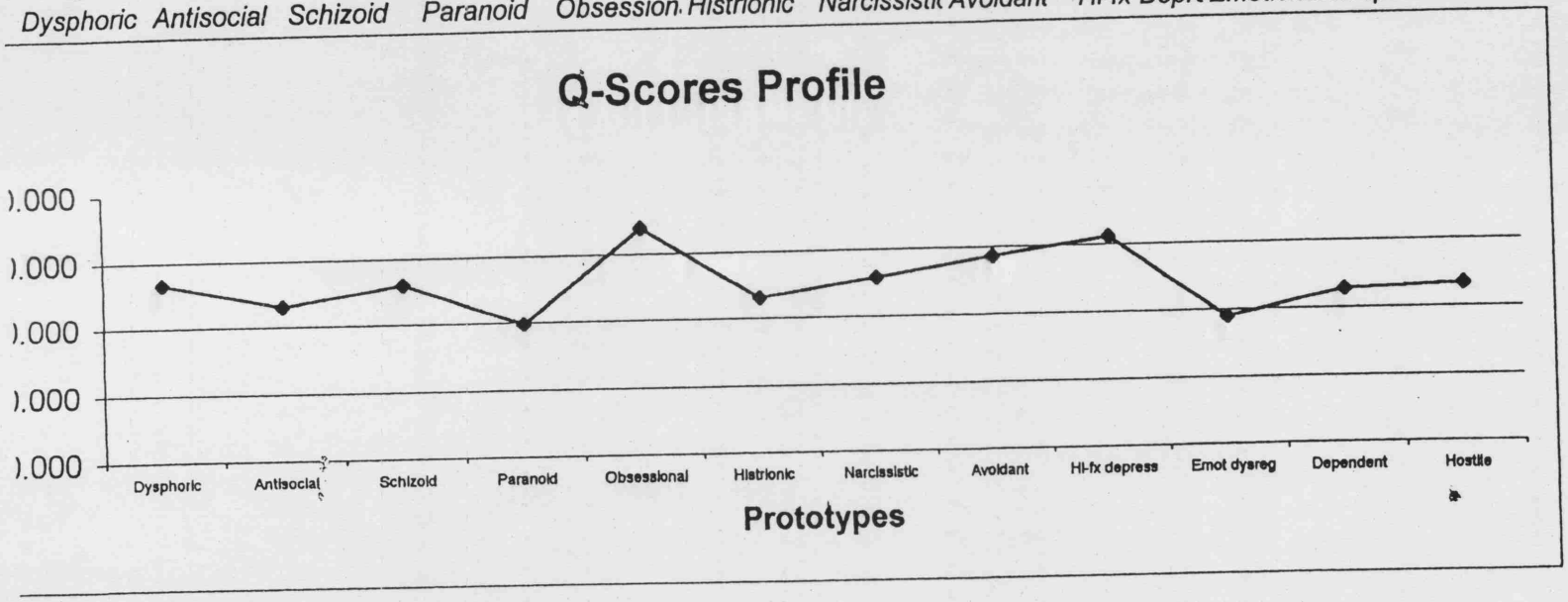
0.329	0.032	0.214	-0.088	0.422	0.092	0.029	0.358	0.341	-0.095	0.095	0.160	0.426
0.349	-0.028	0.066	-0.016	0.607	-0.080	0.073	0.345	0.532	-0.078	-0.101	0.137	0.597
0.365	**0.002**	**0.151**	**-0.056**	**0.555**	**0.007**	**0.055**	**0.379**	**0.471**	**-0.093**	**-0.003**	**0.160**	**0.552**

Agreement between raters in their correlations with Q-scores Profile and T-scores

0.879 Hi-fx= 0.552 verage Corr= 0.154 SD(corr)= 0.225 Normality1= 0.694 Normality2= -0.993

:ores (Q1-Q7)= 50.782 SD(T-scores) 8.778 Average T scores (Q1a-Q1 49.853 SD(T-scores) 9.783

53.057	**45.979**	**51.978**	**39.377**	**67.497**	**46.031**	**51.556**	**57.076**	**62.266**	**37.700**	**45.441**	**46.781**	
Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



Profiles494

Correlations between sort for this subject and Q-score norms

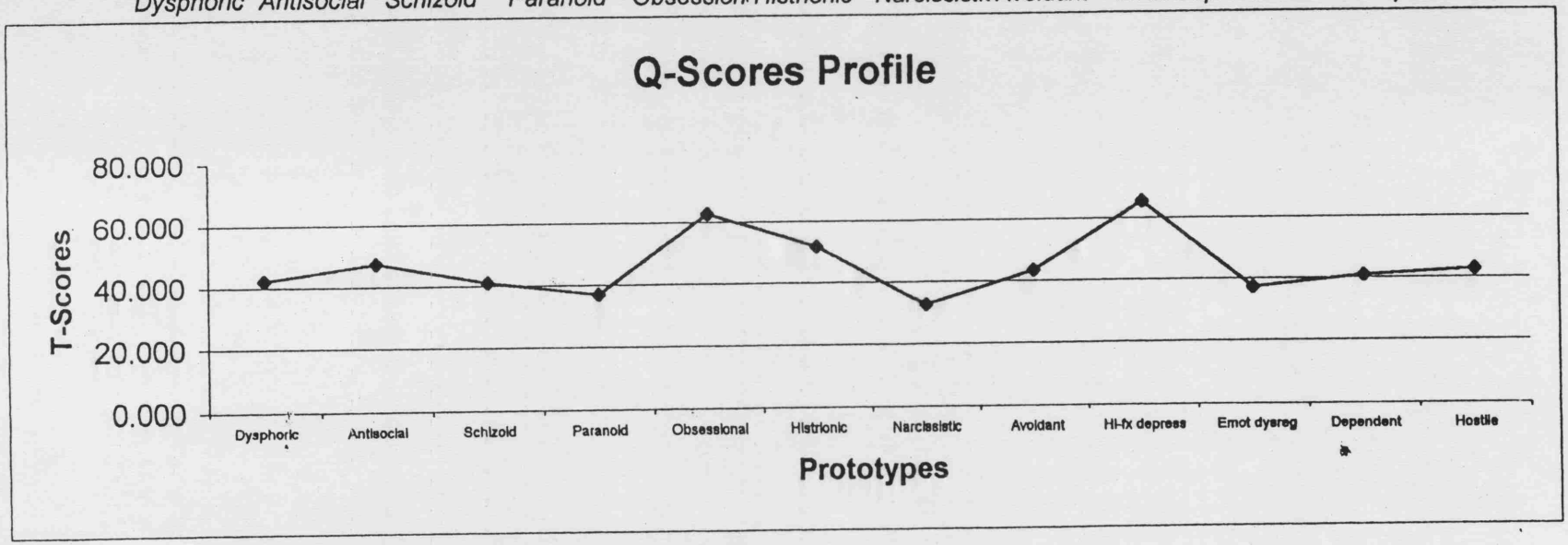
Corr. R1	0.031	0.001	-0.112	-0.117	0.426	0.097	-0.209	-0.041	0.519	-0.122	-0.113	0.063	0.631
Corr. R2	0.126	0.062	-0.100	-0.087	0.415	0.087	-0.163	0.002	0.520	-0.077	-0.054	0.117	0.586
Corr. Av	**0.082**	**0.033**	**-0.111**	**-0.108**	**0.442**	**0.097**	**-0.195**	**-0.020**	**0.546**	**-0.105**	**-0.088**	**0.095**	**0.639**

Agreement between raters in their correlations with Q-scores Profile and T-scores

Reliability (13) 0.992 **Hi-fx= 0.639** **Average Corr= 0.034** **SD(corr)= 0.211** **Normality1= 0.945** **Normality2= -0.679**

Average T scores (Q1-Q7)= 44.807 **SD(T-scores) 10.091** **Average T scores (Q1a-Q1e 45.784** **SD(T-scores) 11.106**

T-scores	**42.134**	**47.277**	**40.964**	**36.699**	**62.653**	**51.516**	**32.407**	**43.227**	**65.182**	**37.115**	**40.685**	**42.713**	
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



Correlations between sort for this subject and Q-score norms

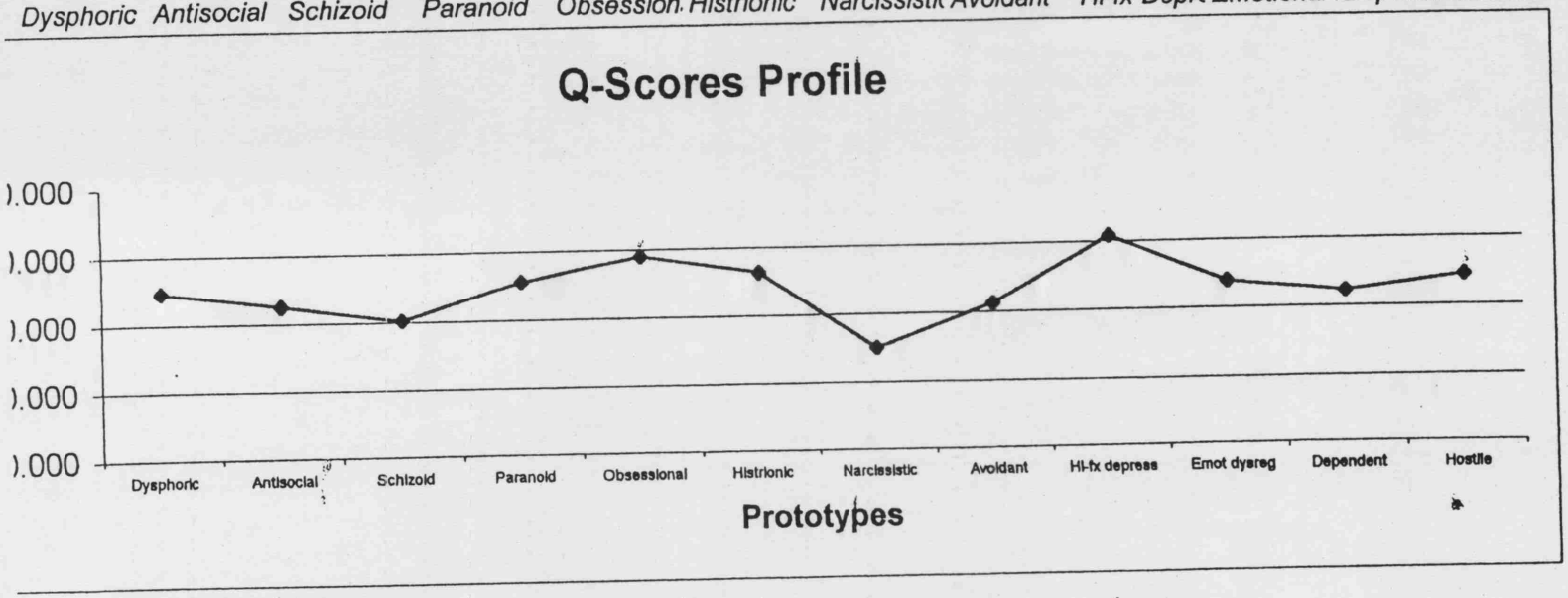
0.269	-0.017	-0.138	0.137	0.297	0.065	-0.239	-0.026	0.440	0.142	-0.062	0.157	0.443
0.217	-0.024	-0.099	0.175	0.321	0.144	-0.183	-0.050	0.394	0.058	0.025	0.203	0.404
0.261	**-0.022**	**-0.127**	**0.167**	**0.331**	**0.112**	**-0.226**	**-0.041**	**0.447**	**0.107**	**-0.020**	**0.193**	**0.454**

Agreement between raters in their correlations with Q-scores Profile and T-scores

0.963 Hi-fx= 0.454 verage Corr= 0.071 SD(corr)= 0.204 Normality1= 0.834 Normality2= -0.658

ores (Q1-Q7)= 46.514 SD(T-scores) 9.151 Average T scores (Q1a-Q1 48.988 SD(T-scores) 7.353

49.025	**44.987**	**40.302**	**50.924**	**57.896**	**52.420**	**30.043**	**42.509**	**61.346**	**47.724**	**44.521**	**48.839**
Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**
Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*

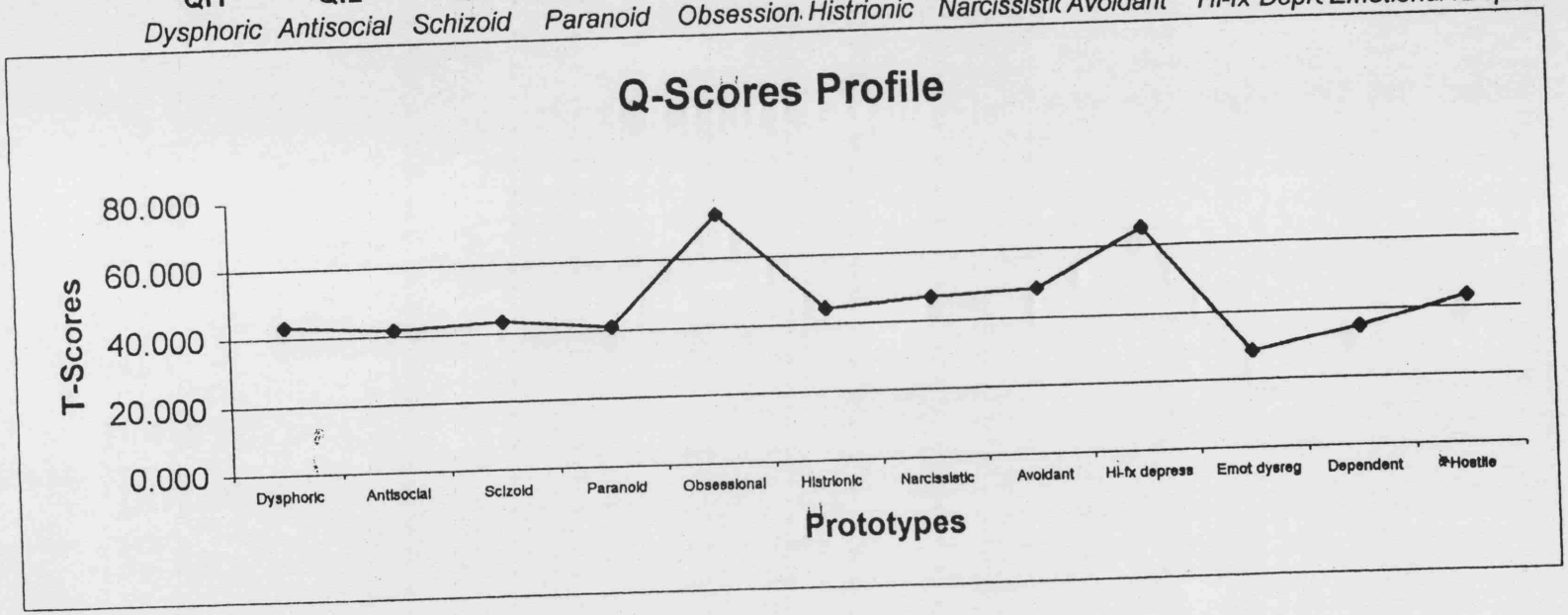


Correlations between sort for this subject and Q-score norms

Corr. R1	0.107	-0.144	0.015	-0.073	0.613	0.008	-0.070	0.188	0.487	-0.304	-0.152	0.069	0.708
Corr. R2	-0.006	-0.015	0.013	-0.066	-0.028	-0.090	0.058	0.045	0.050	-0.079	-0.014	-0.031	0.057
Corr. R2	0.091	-0.052	-0.120	0.023	0.668	-0.044	0.058	0.056	0.545	-0.225	-0.213	0.119	0.725
Corr. Av	**0.105**	**-0.104**	**-0.055**	**-0.027**	**0.679**	**-0.019**	**-0.007**	**0.129**	**0.547**	**-0.281**	**-0.193**	**0.100**	**0.760**

Agreement between raters in their correlations with Q-score Profile and T-scores

Reliability	R1vR2= 0.359		R1vR3= 0.944		R2vR3= 0.301		Mean (R)= 0.535		HI-fx= 0.760				
Average Corr	0.073	SD(corr)= 0.280		Normality1= 0.900		Normality2= 0.158		Average T(Q- 47.561		SD (Tscore)= 11.311		Average T(Q- 43.947	
T-scores	**43.020**	**41.579**	**43.302**	**40.888**	**72.831**	**44.490**	**46.817**	**48.417**	**65.208**	**28.311**	**34.758**	**43.041**	SD (Tscore)= 14.157
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



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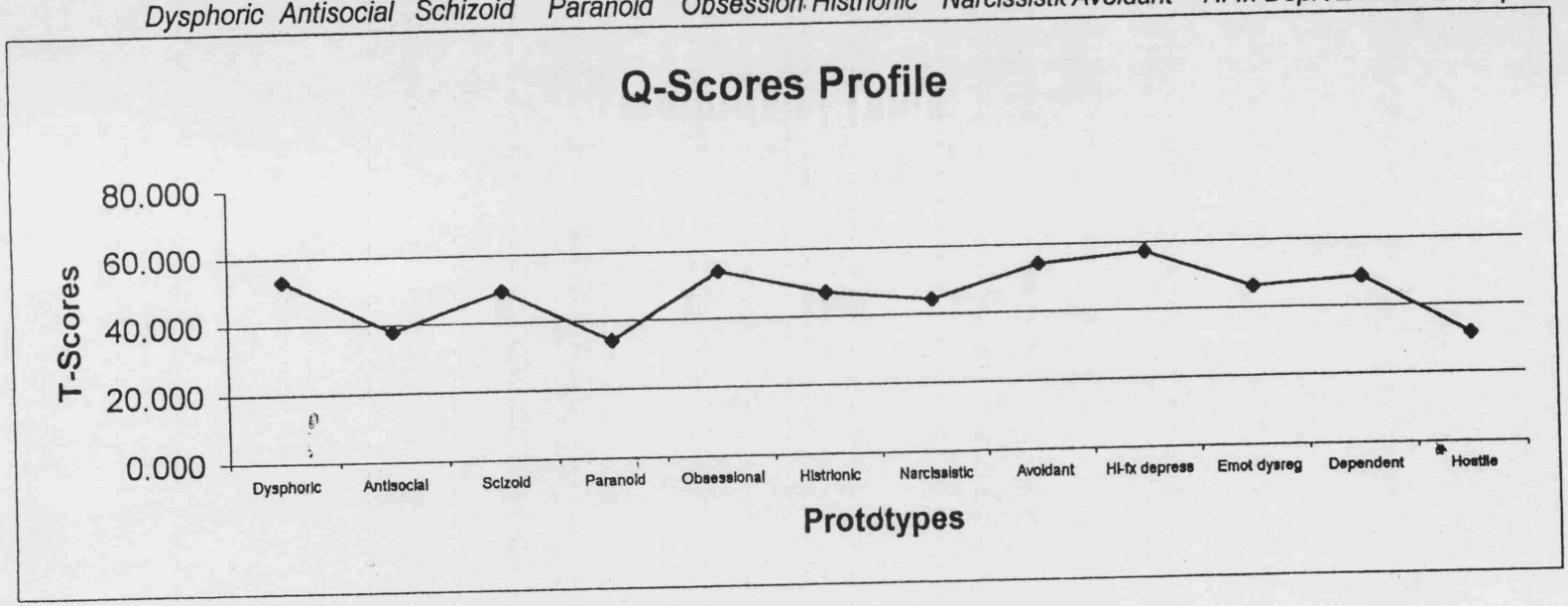
Correlations between sort for this subject and Q-score norms

Corr. R1	0.242	-0.145	0.204	-0.127	0.153	0.069	-0.063	0.293	0.180	0.077	0.032	-0.056	0.232
Corr. R2	0.117	0.006	-0.021	0.102	0.024	-0.037	-0.012	0.058	0.118	0.071	-0.027	0.076	0.017
Corr. R2	0.421	-0.217	-0.054	-0.169	0.283	-0.031	-0.012	0.256	0.447	0.059	0.062	-0.104	0.423
Corr. Av	**0.361**	**-0.197**	**0.081**	**-0.161**	**0.237**	**0.021**	**-0.041**	**0.298**	**0.341**	**0.074**	**0.051**	**-0.087**	**0.356**

Agreement between raters in their correlations with Q-score Profile and T-scores

Reliability	R1vR2= 0.178		R1vR3= 0.796		R2vR3= 0.457		Mean (R)= 0.477		Hi-fx= 0.356				
Average Cor	0.082	SD(corr)= 0.191		Normality1= 0.751		Normality2= -0.001		Average T(Q' 45.511		SD (Tscore)= 7.479		Average T(Q' 47.500	
T-scores	**52.891**	**37.709**	**49.044**	**33.933**	**53.884**	**46.900**	**44.215**	**54.286**	**57.252**	**46.043**	**48.503**	**31.417**	SD (Tscore)=
	Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	10.037
	Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



Profiles503

Correlations between sort for this subject and Q-score norms

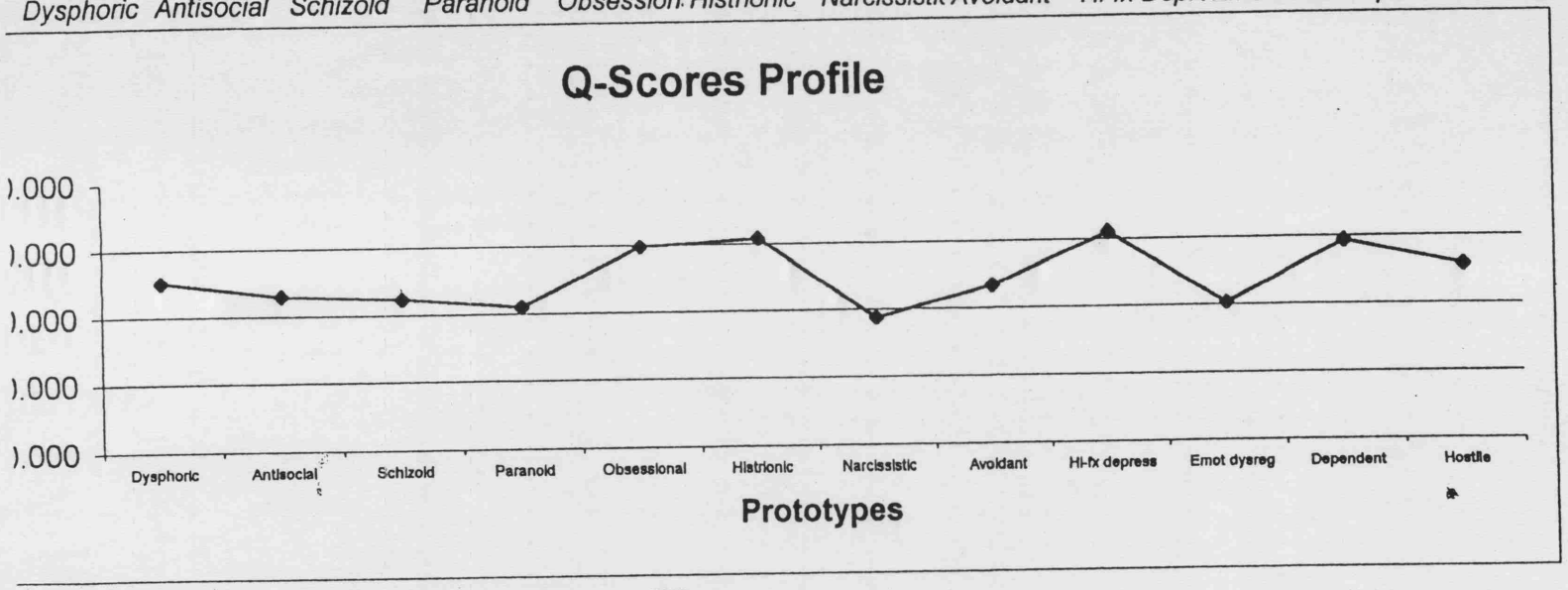
0.284	-0.059	-0.090	-0.026	0.399	0.219	-0.114	0.075	0.541	-0.063	0.176	0.149	0.543
0.255	0.061	0.043	0.014	0.273	0.261	-0.127	0.068	0.307	-0.005	0.248	0.285	0.327
0.292	**0.001**	**-0.025**	**-0.007**	**0.364**	**0.260**	**-0.130**	**0.078**	**0.460**	**-0.037**	**0.230**	**0.235**	**0.471**

Agreement between raters in their correlations with Q-scores Profile and T-scores

0.905 **HI-fx= 0.471** **verage Corr= 0.108** **SD(corr)= 0.192** **Normality1= 0.752** **Normality2= -0.936**

:ores (Q1-Q7)= 48.676 **SD(T-scores) 8.899** **Average T scores (Q1a-Q1 51.782** **SD(T-scores) 8.668**

50.243	**45.920**	**44.566**	**41.930**	**59.307**	**61.398**	**37.370**	**46.621**	**61.841**	**40.499**	**58.514**	**51.433**
Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**
Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



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760

Correlations between sort for this subject and Q-score norms

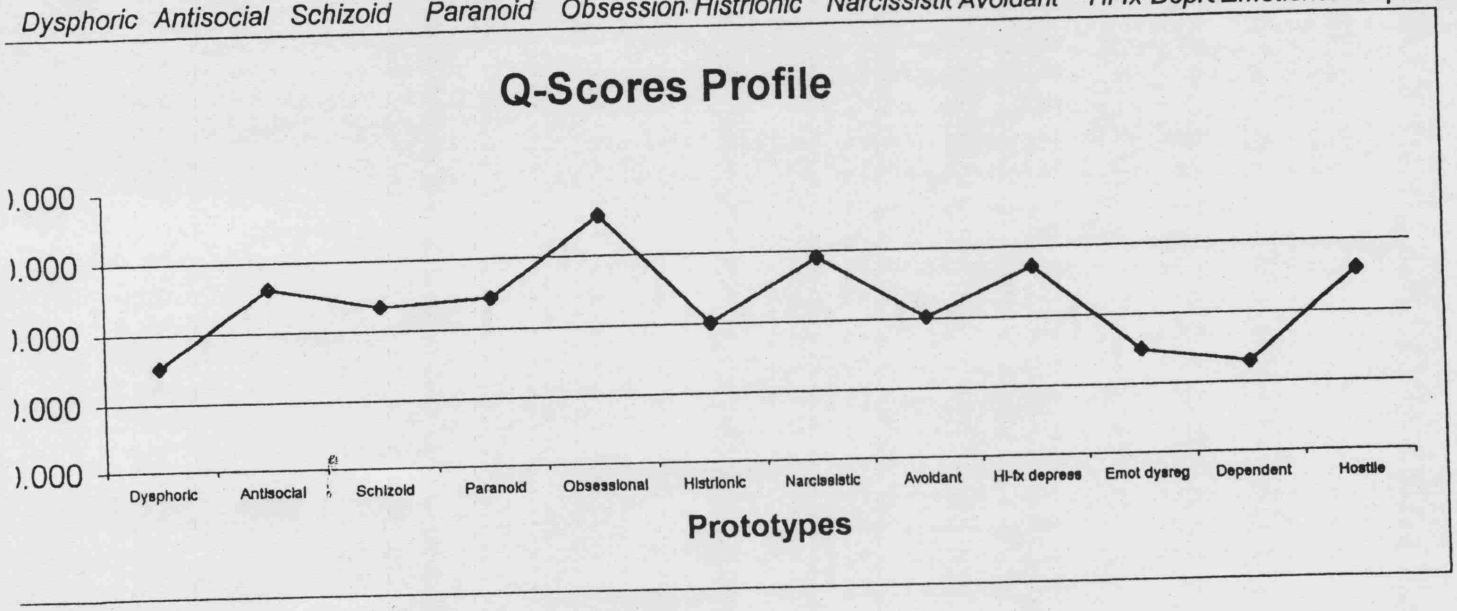
-0.210	0.168	-0.097	0.146	0.563	-0.047	0.193	-0.186	0.284	-0.249	-0.295	0.260	0.488
-0.207	0.119	0.143	0.084	0.624	-0.118	0.070	-0.003	0.201	-0.219	-0.359	0.189	0.447
-0.226	0.155	0.025	0.125	0.644	-0.090	0.142	-0.103	0.263	-0.254	-0.355	0.244	0.507

Agreement between raters in their correlations with Q-scores Profile and T-scores

0.906 HI-fx= 0.507 verage Corr= 0.048 SD(corr)= 0.276 Normality1= 0.828 Normality2= -0.078

:ores= 45.805 SD(T-scores) 13.259

30.238	52.334	46.678	48.751	71.311	40.186	58.199	40.363	54.250	29.666	25.701	51.981
Qf1	Qf2	Qf3	Qf4	Qf5	Qf6	Qf7	Qf1a	Qf1b	Qf1c	Qf1d	Qf1e
Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



Profiles514

Correlations between sort for this subject and Q-score norms

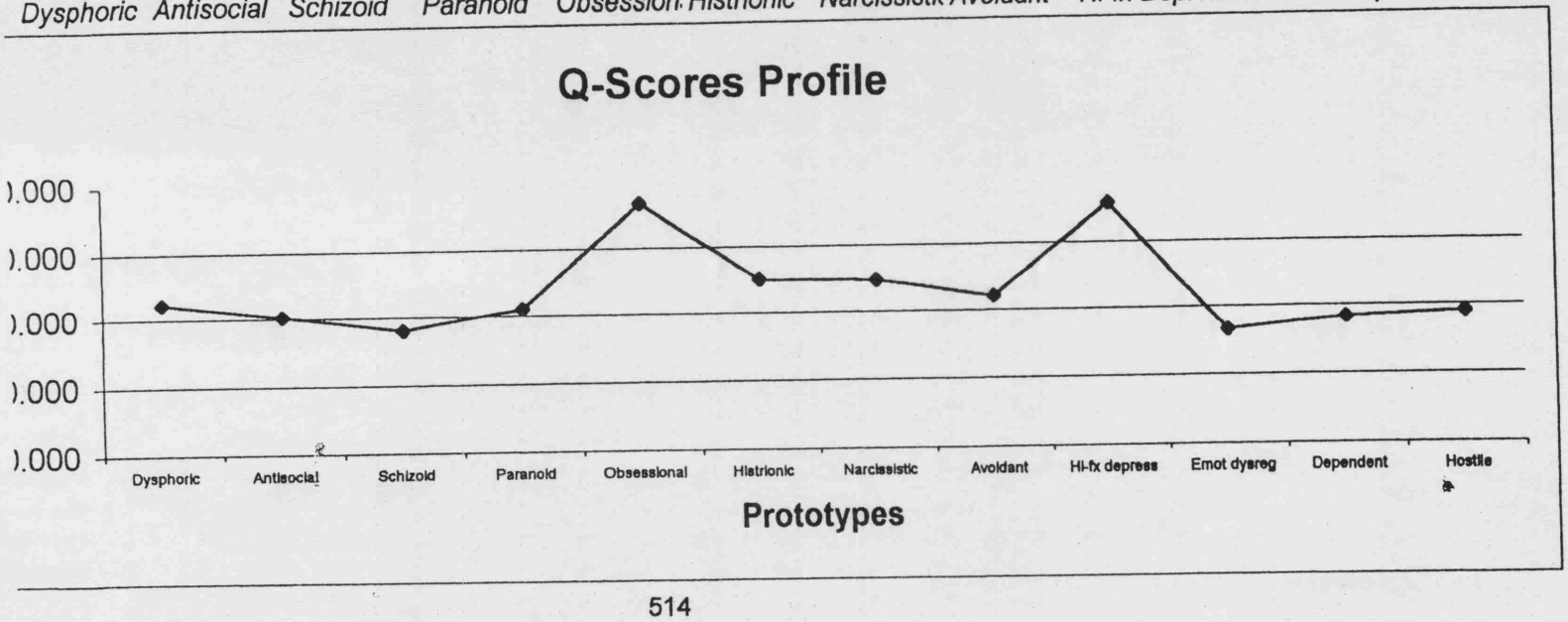
0.144	-0.168	-0.216	-0.010	0.610	0.050	0.016	0.021	0.677	-0.168	-0.171	-0.021	0.792
0.135	-0.086	-0.228	0.000	0.707	0.086	0.039	-0.003	0.668	-0.201	-0.145	0.054	0.788
0.146	**-0.133**	**-0.232**	**-0.005**	**0.689**	**0.071**	**0.029**	**0.009**	**0.703**	**-0.193**	**-0.165**	**0.017**	**0.827**

Agreement between raters in their correlations with Q-scores Profile and T-scores

0.992 HI-fx= 0.827 verage Corr= 0.081 SD(corr)= 0.296 Normality1= 0.898 Normality2= -0.849

:ores (Q1-Q7)= 47.942 SD(T-scores) 12.218 Average T scores (Q1a-Q1 44.491 SD(T-scores) 15.531

44.591	**40.382**	**35.883**	**42.021**	**73.246**	**49.956**	**49.512**	**44.244**	**71.253**	**32.714**	**36.336**	**37.907**	
Qf1	**Qf2**	**Qf3**	**Qf4**	**Qf5**	**Qf6**	**Qf7**	**Qf1a**	**Qf1b**	**Qf1c**	**Qf1d**	**Qf1e**	
Dysphoric	*Antisocial*	*Schizoid*	*Paranoid*	*Obsession*	*Histrionic*	*Narcissistic*	*Avoidant*	*Hi-fx Depr*	*Emotional*	*Dependent*	*Hostile*	*Hi-fx*



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APPENDIX 5.4. THE SWAP ITEMS PERTAINING TO THE TWELVE PERSONALITY FACTORS

Factor I: Psychological Health	*Loading*
Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.	.75
Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.	.75
Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it.	.73
Is creative; is able to see things or approach problems in novel ways.	.73
Is able to use his/her talents, abilities, and energy effectively and productively.	.72
Enjoys challenges; takes pleasure in accomplishing things.	.72
Is empathic; is sensitive and responsive to other peoples' needs and feelings.	.71
Is able to assert him/herself effectively and appropriately when necessary.	.71
Appreciates and responds to humor.	.71
Tends to elicit liking in others.	.67
Is articulate; can express self well in words.	.67
Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others.	.66
Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.).	.65
Appears comfortable and at ease in social situations.	.64
Tends to be energetic and outgoing.	.64
Has an active and satisfying sex life.	.62
Has moral and ethical standards and strives to live up to them.	.58
Tends to be conscientious and responsible.	.56
Factor II: Psychopathy	
Tends to engage in unlawful or criminal behavior.	.80
Tends to show reckless disregard for the rights, property, or safety of others.	.79
Tends to be deceitful; tends to lie or mislead.	.74
Appears to experience no remorse for harm or injury caused to others.	.69
Tends to be unreliable and irresponsible (e.g., may fail to meet work obligations or honor financial commitments).	.68
Takes advantage of others; is out for number one; has minimal investment in moral values.	.67
Tends to be unconcerned with the consequences of his/her actions; appears to feel immune or	.67

invulnerable.	
Tends to act impulsively, without regard for consequences.	.67
Tends to abuse illicit drugs.	.67
Tends to abuse alcohol.	.61
Tends to seek thrills, novelty, adventure, etc.	.58
Seeks to dominate an important other (e.g., spouse, lover, family member) through violence or intimidation.	.54
Repeatedly convinces others of his/her commitment to change but then reverts to previous maladaptive behavior; tends to convince others that "this time is really different."	.53
Tends to break things or become physically assaultive when angry.	.52
Factor III: Hostility	
Tends to be critical of others.	.64
Tends to be angry or hostile (whether consciously or unconsciously).	.62
Is quick to assume that others wish to harm or take advantage of him/her; tends to perceive malevolent intentions in others' words and actions.	.61
Tends to hold grudges; may dwell on insults or slights for long periods.	.61
Tends to express intense and inappropriate anger, out of proportion to the situation at hand.	.60
Tends to be oppositional, contrary, or quick to disagree.	.59
Tends to get into power struggles.	.56
Tends to elicit dislike or animosity in others.	.52
Tends to feel misunderstood, mistreated, or victimized.	.50
Factor IV: Narcissism	
Seems to treat others primarily as an audience to witness own importance, brilliance, beauty, etc.	.75
Appears to feel privileged and entitled; expects preferential treatment.	.69
Has fantasies of unlimited success, power, beauty, talent, brilliance, etc.	.68
Seeks to be the center of attention.	.65
Has an exaggerated sense of self-importance.	.63
Tends to be arrogant, haughty, or dismissive.	.57
Tends to believe s/he can only be appreciated by, or should only associate with, people who are high-status, superior, or otherwise "special."	.55

Tends to think others are envious of him/her.	.50
Factor V: Emotional dysregulation	
Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.	.68
Emotions tend to change rapidly and unpredictably.	.68
Expresses emotion in exaggerated and theatrical ways.	.66
Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.	.56
Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.	.51
Tends to be overly needy or dependent; requires excessive reassurance or approval.	.48
Tends to "catastrophize"; is prone to see problems as disastrous, unsolvable, etc.	.45
Factor VI: Dysphoria	
Tends to feel s/he is inadequate, inferior, or a failure.	.60
Tends to feel life has no meaning.	.58
Tends to feel empty or bored.	.55
Tends to feel unhappy, depressed, or despondent.	.54
Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.	.52
Tends to avoid social situations because of fear of embarrassment or humiliation.	.51
Tends to feel ashamed or embarrassed.	.50
Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.	.49
Tends feel listless, fatigued, or lacking in energy.	.48
Factor VII: Schizoid Orientation	
Appears to have little need for human company or contact; is genuinely indifferent to the presence of others.	.58
Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance.	.57
Appears unable to describe important others in a way that conveys a sense of who they are as people; descriptions of others come across as two-dimensional and lacking in richness.	.52
Has little or no interest in having sexual experiences with another person.	.46
Tends to elicit boredom in others (e.g., may talk incessantly, without feeling, or about [illegible])	.46

inconsequential matters).	
Lacks close friendships and relationships.	.45
Appears to have a limited or constricted range of emotions.	.43
Has little empathy; seems unable to understand or respond to others' needs and feelings unless they coincide with his/her own.	.40
Factor VIII: Obsessionality	
Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.	.72
Tends to become absorbed in details, often to the point that s/he misses what is significant in the situation.	.70
Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.	.62
Tends to be preoccupied with concerns about dirt, cleanliness, contamination, etc. (e.g., drinking from another person's glass, sitting on public toilet seats, etc.).	.54
Is troubled by recurrent obsessional thoughts that s/he experiences as senseless and intrusive.	.52
Tends to be stingy and withholding (whether of money, ideas, emotions, etc.)	.44
Tends to think in abstract and intellectualized terms, even in matters of personal import.	.44
Has difficulty discarding things even when they are worn-out or worthless; tends to hoard, collect, or hold onto things.	.43
Is excessively devoted to work and productivity, to the detriment of leisure and relationships.	.42
Factor IX: Thought disorder	
Reasoning processes or perceptual experiences seem odd and idiosyncratic (e.g., may make seemingly arbitrary inferences; may see hidden messages or special meanings in ordinary events).	.70
Tends to be superstitious or believe in magical or supernatural phenomena (e.g., astrology, tarot, crystals, ESP, "auras," etc.).	.60
Perception of reality can become *grossly* impaired under stress (e.g., may become delusional).	.49
Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or "off").	.49
Speech tends to be circumstantial, vague, rambling, digressive, etc.	.45
Is extremely identified with a social or political "cause," to a degree that seems excessive or fanatical.	.41
Feels some important other has a special, almost magical ability to understand his/her innermost thoughts and feelings (e.g., may imagine rapport is so perfect that ordinary efforts	.40

at communication are superfluous).	
Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe the self and another person, believe the two share identical thoughts and feelings, treat the person as an "extension" of him/herself, etc.).	.37
Factor X: Oedipal conflict	
Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.	.63
Tends to become attached to, or romantically interested in, people who are emotionally unavailable.	.60
Tends to become involved in romantic or sexual "triangles" (e.g., is most interested in partners who are already attached, sought by someone else, etc.).	.59
Tends to be overly sexually seductive or provocative, whether consciously or unconsciously (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to "lead people on," etc.).	.54
Fantasizes about finding ideal, perfect love.	.44
Tends to be sexually possessive or jealous; tends to be preoccupied with concerns about real or imagined infidelity.	.38
Factor XI: Dissociated consciousness	
Tends to describe experiences in generalities; is unwilling or unable to offer specific details.	.59
Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying non-verbal messages.	.57
Appears to experience the past as a series of disjointed or disconnected events; has difficulty giving a coherent account of his/her life story.	.53
Tends to repress or "forget" distressing events, or distort memories of distressing events beyond recognition.	.52
Tends to enter altered, dissociated state of consciousness when distressed (e.g., the self or the world feels strange, unfamiliar, or unreal).	.38
Expresses contradictory feelings or beliefs without being disturbed by the inconsistency; has little need to reconcile or resolve contradictory ideas.	.37
Factor XII: Sexual conflict	
Appears to associate sexual activity with danger (e.g., injury, punishment, contamination, etc.), whether consciously or unconsciously.	.70
Tends to feel guilty or ashamed about his/her sexual interests or activities (whether consciously or unconsciously).	.58

Tends to see sexual experiences as somehow revolting or disgusting.	.54
Experiences a specific sexual dysfunction during sexual intercourse or attempts at intercourse (e.g., inhibited orgasm or vaginismus in females, impotence or premature ejaculation in males).	.48
When romantically or sexually attracted, tends to lose interest if other person reciprocates.	.36
Has difficulty directing both tender feelings and sexual feelings toward the same person (e.g., sees people as respectable and virtuous, or sexy and exciting, but not both).	.35

Note: Included above are items loading above .50 (Factors 1-4), .45 (Factors 5-6), .40 (Factors 7-8), or .35 (Factors 9-12). As common in factor-analytic research, we progressively relaxed criteria for inclusion (from .50 to .35) to maximize reliability of the smaller factors. No item listed here loaded > .35 on any secondary factor.

APPENDIX 6.1. FULL LIST OF 32 ANALZYED CHILDHOOD VARIABLES

I. Demographic and Family Variables:

1. Family RGC
2. Father Country of Birth
3. Mother Country of Birth
4. Father Religion
5. Mother Religion

II. Parents' Mental Health and Global Functioning:

1. Mother Past DSM Diagnosis
2. Mother DSM Diagnosis at Assessment
3. Mother GAF Score
4. Father Past DSM Diagnosis
5. Father DSM Diagnosis at Assessment
6. Father GAF Score
7. Mother Psychiatric History at Assessment
8. Mother Past Psychiatric History
9. Father Psychiatric History at Assessment
10. Father Past Psychiatric History
11. Presence of Parental DSM Diagnosis (past or present)

III. Child and Clinical Variables:

1. Gender
2. Age at Start of Treatment
3. Patient Past DSM Diagnosis
4. Patient HCAM Score
5. Number of Referral Diagnoses
6. Number of Learning Difficulties
7. IQ Score

IV. Treatment Variables:

1. Session Frequency
2. Length of Treatment (in years)
3. Primary Reason for Termination
4. Parent Guidance During Treatment

V. Termination Variables:

1. Presence of DSM Diagnosis at Termination
2. Number of Termination Diagnoses
3. Termination HCAM Score
4. HCAM Change Score
5. Subsequent Treatment at AFC or Elsewhere

APPENDIX 6.2. CORRELATION MATRIX BETWEEN CHILDHOOD VARIABLES AND THE ADULT FUNCTIOING INDEX

Correlations

	AFI		
	Pearson Correlation	Sig. (2-tailed)	N
B3 - Session Frequency (Max)	.167		
C3 - Age at Start of Treatment	-.100	.344	34
D3 - Length of Treatment in Years	.040	.573	34
G3 - Mother Past DSM Diagnosis	.221	.822	34
H3 - Mother DSM diagnosis at Assessment	.267	.210	34
I - Mother GAF Score	.396(*)	.127	34
J3 - Father DSM Diagnosis at Assessment	.203	.020	34
K3 - Father GAF Score	.384(*)	.250	34
L3 - Father Past DSM Diagnosis	.250	.025	34
M3 - Patient Past DSM Diagnosis	.274	.153	34
O3 - Patient HCAM Score	.471(**)	.117	34
P3 - Termination DSM Diagnosis	.411(*)	.005	34
Q3 - Termination HCAM Score	.420(*)	.016	34
QA3 - HCAM Score Change	.155	.013	34
U3 - Average Full IQ	.361(*)	.380	34
W3 - No. of Ref. Diagnoses (DSM/ICD)	-.356(*)	.036	34
Y3 - Type of Principal Ref. Diagnosis (Emotional/Disruptive, etc.)	.263	.039	34
AB3- No. of Termination Diagnoses	-.466(**)	.055	34
AQ3 - Family RGC	-.152	.390	34
AW3 - Subsequent Treatment at AFC or Elsewhere	.021	.906	34
AY3 - Parent Guidance During Treatment	-.022	.902	34
BE3 - Number of Learning Difficulties	-.287	.099	34
BI3 - Mother Psychiatric History-Assessment (present/absent)	-.074	.679	34
BJ3 - Mother Psychiatric History - Past (present/absent)	-.033	.854	34
BL3 - Father Psychiatric History-Assessment (present/absent)	-.273	.119	34
BM3 - Father Psychiatric History - Past (present/absent)	.044	.805	34

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

APPENDIX 6.3. A PRESENTATION OF ASSESSMENT AND TERMINATION HCAM SCORES, AFI SCORES, AND ATTACHMENT CLASSIFCATION ASSIGNMENTS

ID No.	Assessment HCAM score	Termination HCAM score	Adult Functioning Index score	Adult attachment classification
001	41	41	30	E
399	41	-	49	D
123	48	35	54	E
390	48	50	55	U/E
503	50	65	67	E
285	50	90	76	CC/E
009	51	-	63	U/E
077	52	70	66	U/E
253	53	75	68	U/E
170	55	69	65	D
337	55	63	78	U/D
500	55	-	55	D
007	58	58	72	F
210	58	90	64	CC/E
332	58	66	85	D
496	58	-	82	U/E
003	62	80	79	E
361	63	70	72	D
208	65	50	70	U/E
454	67	80	75	D
013	70	-	53	CC/E
177	70	-	78	U/E
158	50	55	82	U/F
436	50	83	86	F
494	54	88	85	F
152	55	75	86	F
175	55	-	91	F
514	55	60	82	F
497	58	85	86	F
053	59	78	83	F
507	60	78	86	F
011	61	-	82	F
434	68	80	82	F
005	83	-	88	F

- Termination HCAM scores could not be determined from case files and were estimated with the SPSS missing value estimation procedure for statistical analyses.
- **HCAM score range**: Below 40 = severe, disabling symptoms; 40-49 = moderate, widespread impairment; 50-59 = several areas impaired; 60-69 = single area of difficulty; 70-79 = minimal impairment; 80-89 good functioning in all areas.
- **Attachment classification groups**: F = secure; D = Insecure/Dismissing; E = Insecure/Preoccupied-Entangled; U = Unresolved on loss or abuse; CC = Cannot classify.

APPENDIX 6.4. CLINICAL ILLUSTRATIONS OF PATHWAYS BETWEEN DYSFUNCTIONAL GLOBAL FUNCTIONING IN CHILDHOOD AND ADULTHOOD

The childhood histories of four particularly disturbed follow-up subjects is explored here in greater detail in order to better understand the background variables underlying the depth of their adult disturbance. At the outset, it is important to state that each individual and his family circumstances are unique and it is both impossible and undesirable to force a particular model upon them. Yet, there are certain themes that emerged in the reading of these cases that are of clinical interest. In no way is this discussion an attempt to minimize the individual differences and unique life circumstances of these individuals. For purposes of discussion I will refer to the four subjects by a capital letter that in no way bears connection to their names.

Initial Presentation

In terms of their initial presentation it is of interest to note that in all four cases the clinicians made note of current psychotic features or a worrisome prognosis of psychotic breakdown in adolescence. This clearly sets them apart from neurotic cases. Mr. O. (ID no. 399) was referred to the AFC at age seven with a history of hallucinatory symptoms from as early as age four. He was hospitalized at age four for one month due to high fever and serious psychological disturbance, including hallucinations, and his parents reported that he often had difficulty distinguishing between dreams and reality. Mr. Q. (ID no. 390) arrived at the AFC at age nine but had been diagnosed earlier as functioning at a "borderline psychotic level", exhibiting morbid obsessional thoughts and extreme persecutory anxiety. Intensive treatment was recommended due to a fear that adolescence would bring with it psychotic features. Mr. V. (ID no. 001) was referred at a similar age to Mr. Q. In his file, the analyst highlighted his regressive tendencies and the danger of suicide or regressive withdrawal in adolescence, possibly leading to psychosis. Finally, Mr. S. (ID no. 001) was referred to the clinic at age fourteen. The diagnostic conference relating to his case included a discussion of the possibility of psychosis. So, too, towards the end of his treatment his analyst remarked on his identification with the insane aspects of his internal objects and questioned whether he was on his way to a 'psychosomatic suicide'.

Symptomatology

Certain behavioral descriptions were common to all four subjects. In all cases, parents reported intense difficulties related sleep and often mothers were required to sleep alongside their sons for hours, on a nightly basis, before their child could fall asleep. Sleep problems had been ongoing for many years. In addition, parents described intense and often violent tantrums that were displayed both at home and at school. Indeed, for all of the subjects, school attendance was problematic and all of them had come to the attention of the teaching staff due to learning difficulties and/or unusual behavioral problems. All four were described as being socially isolated, without a single friend. Clinicians described these patients as 'odd' and 'immature' and all were preoccupied by morbid themes as well as bodily functions, often in an obsessional manner.

Family Background

In all four cases, the parental relationship was described as highly conflictual, characterized by intense hostility and, at times, physical aggression. In the case of Mr. O., his mother reported intense marital difficulties that predated his birth. In all cases, these difficulties included problems related to the parents' sexual life. The fathers of both Mr. O. and Mr. Q. suffered from severe impotence. Mr. S.'s parents' described very infrequent sexual contact and there was a note in the file referring to the father's possible bisexuality. Mr. V.'s parents reported sexual difficulties as well. The father experienced many homosexual relationships from adolescence and through adulthood; both parents were involved in extra-marital affairs during Mr. V.'s youth, until their divorce.

Regarding the psychiatric history of the subjects' parents and extended families, the following information is known: Mr. O.'s mother suffered from postpartum depression following the birth of both her children; at the time of Mr. O.'s referral she was seeing a psychiatric social worker for her own difficulties. She related that a maternal cousin had attempted suicide, and that both her maternal aunt and grandmother had suffered from depression. Mr. O's father suffered from depression related to his impotence and had experienced outpatient psychiatric treatment in his past. Mr. Q.'s father was assessed at the time of referral as suffering from an

immature personality disorder, and dysthymia due to impotence. In addition, there was indication that he suffered from either a paranoid or depressive illness following Mr. Q.'s birth, which went on for many years, which eventuated in his suicide when Mr. Q. was 18. Mr. S.'s parents were both assessed as suffering from ongoing anxiety disorders. In addition, the mother was diagnosed as suffering from a personality disorder N.O.S. and from parent-child problems (to be described below); she had received treatment at an outpatient clinic in the past. Finally, Mr. V.'s mother suffered a severe breakdown following his birth, possibly with psychotic features; however she looked after Mr. V. and his sister on her own, for a long time, despite an apparently regressed state. At the time of assessment, she suffered from both anxiety and depressive disorders. The father was assessed as suffering from a depressive disorder as well as from a sexual dysfunction.

Within the framework of the current study, it is difficult to weigh the genetic influence of parental and familial psychiatric disturbance, although they should not be dismissed. One can assume that the breakdowns of two of the mothers and one father following the birth of these individuals had profound effect on the parents' emotional functioning in these children's earliest development. One can imagine a highly volatile and unpredictable emotional environment, a frightening milieu for a newborn infant whose ability to distinguish and make sense of the vast surrounding stimuli is just emerging, at a time when s/he is so highly dependent on his or her caretakers to protect, moderate, filter and give meaning to these early sensations and experiences. What seems common to all four cases is a lack of boundaries between parent and self, a lack of distinction between self and other on the most basic of levels. In the case of Mr. S., the clinician commented on the mother's total inability to separate herself from her son, viewing his highly abnormal behavior at school as ego-syntonic. Thirty-some years later, her son is still grappling with his utter dependence on her. He understands on some level that this relationship is detrimental to him, yet feels utterly incapable of freeing himself from this highly symbiotic and intrusive relationship. During the course of his AAI, Mr. S. was discussing his mother's over-protectiveness and unwanted interference in every aspect of his life. While complaining that mother treats him like a child, like a girl, he says, "I can't get away from them, I don't want to get away from them." As predicted by his analyst, Mr. S. has remained trapped within a highly enmeshed family dynamic wherein mother is overly domineering and

father remains completely passive, almost non-existent. Although Mr. S. was able to leave home for three years while at university, at the time of the follow-up interviews he was totally reliant on his parents financially, ostensibly due to the accumulation of staggering debts. Increasingly, his parents who had recently retired were becoming dependent on him, their only child, because of their poor health and increasingly demanding physical needs.

Mr. V. also comes across as lacking a self that is distinct from his parents, particularly his mother. Here too the parents did not perceive Mr. V.'s odd behavior as unusual or worrisome and the analyst felt that Mr. V. provided a vehicle for each of the parents to express their own craziness, acting out through him. Mother spent hours sleeping in Mr. V.'s bed to help him fall asleep, and although father was not passive in this regard, his intense aggression toward his son resulted in frightening rages toward him. In response, Mr. V. clung ever more steadfastly to mother and refused contact with father. The analyst who assessed Mr. V. commented on a family environment in which impulsive acting out occurred and in which he was relatively protected from reality demands. This was, perhaps, most profoundly expressed in the mother's relation to Mr. V.'s difficulty in separating from her and attending school. There was no attempt on her part to enforce school attendance and it would appear that she indeed colluded with him, as he spent two years outside of any school framework. Although Mr. V.'s mother was not intrusive in style, her so-called 'liberal' attitude toward discipline and childrearing seems to reflect a lack of boundary and differentiation. Mr. V. stated: "I leaned on my mother a lot. One of my big problems was I couldn't sleep at night. I could get very close to her if I wanted. She understood me in every situation; she was always on my side. She never pushed me away, she accepted me very much, even when I was crazy." In Mr. V.'s case, mother represented a safe haven to which he could repeatedly return when his unsuccessful forays into the outside world confronted him with his utter inability to function; a place with no demands, where time, responsibility and boundaries do not exist.

In the case of Mr. O., the subject seems less engulfed by a symbiotic relationship with mother and more overwhelmed by early instinctual drives, although the mother was described by the analyst as intrusive and over-protective. The therapist made note of the obvious absence of oedipal material and theorized that Mr. O.'s hostility toward

his sister's birth was directed against mother beginning in the anal phase, and that in the phallic phase "his persisting ambivalence greatly interfered with the full development of his positive oedipal wishes for his mother."

In the case of Mr. Q., the analytic staff of the AFC debated the interplay between seemingly organic deficiencies (which did not show up in any of the testing) and psychological disturbances. Two aspects of his parents' personalities seem relevant here. Regarding his mother, both analyst and subject (in his attachment interview) referred to her tendency to remove herself, becoming expressionless, when something seemed to frighten or disturb her. This tendency alternated dramatically with her usually animated style of speech. In his AAI, Mr. Q. described his mother as sulking or withdrawing: "She used to shut herself off. She used to have this technique of blocking herself off from anything which would cause a quarrel." This absenting herself from interactions was clearly upsetting to Mr. Q. In addition, his father who seemed to suffer from a volatile and explosive disorder (possibly manic-depression) was frightening in his inconsistency. He appeared mostly uninvolved and the therapist had the impression that the father actually knew very little about his son. Rather than an enmeshed or undifferentiated family dynamic, Mr. Q. seemed to have grown up in emotional solitude, broken only by fleeting yet frightening impingements. Consequently he was forced to develop without a backdrop, without an 'other' against whom to discover and define himself (except for glimpses of contradictory and fragmented images), having to cope with his internal drives and impulses alone. Mr. Q. left treatment after 4.5 years in order to enter a boarding school. He asked to maintain contact with his therapist at term breaks and did so for four years. The analyst's comments indicated that Mr. Q. had for the first time developed mutual friendships and although he remained rather odd and somewhat isolated socially, he had developed skills and interests and long-term goals and was quite proud of his achievements. Tragically, at age 18, Mr. Q's father, apparently in a psychotic state, hanged and killed himself. Mr. Q. insisted on identifying the body for fear that otherwise he would not be able to accept the reality of his father's death. One can only guess at the ways in which his father's suicide affected Mr. Q. His AAI transcript is filled with remorse and guilt over hurtful things he had said to his father preceding his death, comments which appeared to have reflected a more consolidated sense of self and a desire to distinguish between his and his father's wishes and

perceptions. We can only speculate whether this tragedy truncated his individuation process. At the time of the follow-up interviews, Mr. Q. was functioning adequately within the work and friends domain, although clearly not problem-free. He had not ventured into the realm of intimate relations in all of his adult life and remained fundamentally a loner, somewhat strange, with unusual and odd thought processes.

The four individuals described above represent the more severely disturbed extreme of the current sample and exemplify the way in which poor initial global functioning in childhood is predictive of poor long-term outcome. More specifically, these highly disturbed individuals would seem to indicate that there is a level of psychopathology that is qualitatively different in its lack of responsiveness to psychoanalytic intervention in childhood. Indeed, they raise serious questions about the extent to which treatment of any kind can be helpful, highlighting the importance of matching appropriate and effective treatments to individuals suffering from specific types of disorders or degrees of disturbance. Moreover, they underscore the need for meaningful preventive interventions that help individuals to develop in psychologically healthy ways not only in childhood but across their life span, reducing long-term personal suffering and extensive depletion of mental health resources.